MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08201 — 08203

1. DECEASED-NAME (Type or print): First: RACHAEL (Rachel Agg) Middle: — Last: AGG
2a. DATE OF DEATH: Month: JUNE Day: 1 Year: 1971
2b. HOUR: 12:15 AM
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: MARCH 10 1888
6. AGE (In years last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): IOWA
7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): CUMBERLAND NURSING HOME
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Librarian
12b. KIND OF BUSINESS OR INDUSTRY: Seminary
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 1424 LAUREL COURT
14. FATHER'S NAME First: HENRY Middle: — Last: AGG
15. MOTHER'S MAIDEN NAME First: Sarah Pansy Middle: — Last: —
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.:
17. INFORMANT: MRS Joseph H. Hoyer Address: CUMERLAND MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident. — Approximate interval between onset and death: days
DUE TO, OR AS A CONSEQUENCE OF
(b): Atherosclerotic vascular disease — yes.
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse lost.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Nephrosclerosis.

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that (I) (this haspital) attended the deceased from 4/20, 19 71, to 5/31, 19 71, that (I) (we) last saw the deceased alive on 5/7 19 71, and that in (my) (aur) apinian death occurred on the date and haur and from the causes stated abave. (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE: [signature] MD DEGREE — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 6/1/71
22d. PHYSICIAN'S NAME (Type): P.S. HALMOS
22e. ADDRESS: 302 Seiley st. Cumberland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: June 4, 1971
23c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
23d. LOCATION (City or Town) (County) (State): Oskaloosa, Iowa

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JUN 4 1971
25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2[illegible] hrs after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form VS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08202

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08204

1. DECEASED-NAME (Type or Print) First: Benjamin	Middle: Frank	Last: Alderton	2a. DATE KNOWN OF DEATH ESTIMATED [X] Month: 6 Day: 18 Year: 71	2b. HOUR: 1a M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 3/ 4/1906	6. AGE (In years last birthday): 65 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month: June Day: 18, Year: 1971	2d. HOUR: 9a M
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): York Hotel 202 Baltimore Avenue	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Footer	12b. KIND OF BUSINESS OR INDUSTRY: Dye Works		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 202 Baltimore Ave.	
14. FATHER'S NAME First: Cecil	Middle:	Last: Alderton	15. MOTHER'S MAIDEN NAME First: Bertha	Middle:	Last: Troutman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-05-6982	17. INFORMANT: Mrs. J. Wayne Alderton	ADDRESS: Cumberland Md 305 Pulaski St		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Sclerosis — ---

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** thot I took charge of the remoins described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinian deoth resulted from: Natural causes [X], Accident [ ], Suicide [ ], Hamicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: June 18, 1971

ADDRESS(Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/21/1971	Hillcrest Burial Park	Nr. Cumberland Alleg Md

24. FUNERAL DIRECTOR	25. ADDRESS	26. REC'D BY REGISTRAR DATE	26b. REGISTRAR'S SIGNATURE
John J. Stofer,	Balto Ave Cumberland Md	JUN 22 1971	Vernon R. Randall

VR A15ME (5)
10M REV. 1/68

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08203

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08205

1. DECEASED-NAME (Type or print) First: ELIZABETH Middle: B Last: BAKER	2a. DATE OF DEATH Month 06 Day 02 Year 71	2b. HOUR 5:15P	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 11-2-08	6. AGE (In years last birthday) 62 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): AUSTRIA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: RT#1, BOX 207			
14. FATHER'S NAME First: PAUL Middle: Last: BUGOSH	15. MOTHER'S MAIDEN NAME First: ANNA Middle: Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.	

50

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1

MEDICAL CERTIFICATION

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Metastatic Malignant melanoma	1 1/2 yrs
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

1729

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus, Renal failure, uremia

2

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 5-30, 19 71, to 6-2, 19 71, that (I) ~~(we)~~ last saw the deceased alive on 6-2 19 71, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: Andrew Stasko MD DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 6-2-71
22d. PHYSICIAN'S NAME (Type): DR. ANDREW STASKO	22e. ADDRESS: CUMBERLAND, MD.	

1

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: June 5, 1971	23c. NAME OF CEMETERY OR CREMATORY: ST. PATRICK'S CEMETERY	23d. LOCATION (City or Town) (County) (State): MT. SAVAGE ALLEGANY Md.
24. FUNERAL DIRECTOR: HAFER-SOWERS FUNERAL HOME Gary L. Bonsky	ADDRESS: 60 W MAIN ST. FROSTBURG Md	25a. REC'D BY REGISTRAR DATE: JUN 9 1971	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08204

CERTIFICATE OF DEATH

08206

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
LEONA	B.	BENNETT	6	22	71	4:55 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	4 22 96	75 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
PA.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	HOUSEWIFE	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☐ NO ☒	RT 3 BOX 324A

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
GEORGE	KENNARD		JOSEPHINE		ROBISON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	220 03 7993	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Advanced Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1wk

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Diabetes Mellitus, Congestive Heart Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 1960, 19__, to 6-22, 1971, that (I) (we) last saw the deceased alive on 6-22 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
William P James					6/24/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. W. P. JAMES	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/25/71	Fairview Cemtery	Artemas Bedford Pa.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William G. Kight Cumberland, Md.	JUN 28 1971	Vernon B. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08205

CERTIFICATE OF DEATH

08207

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
James		Boyd	6	2	71	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Male	White	4/22/1913	58 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Md	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Miners Hospital	Kelly Tire Co	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Allegany	Lonaconing	YES [X] NO [ ]	11 Park Place

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James		Boyd	Anna		Pollick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
yes W.W.2	216-05-2907	Mrs. Elizabeth Boyd "Wife"	Lonaconing, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of Rt. Lung.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 months ?

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
NONE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
✓	✓	YES [ ] NO [X]	✓

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
✓	✓	✓

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	✓	✓			

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to 6-2, 1971, that (I) (we) last saw the deceased alive on 6-2 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Martin Rothstein		[X]	[ ]	[ ]	6-4-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MARTIN M. ROTHSTEIN M.D.	48 BROADWAY – FROSTBURG – MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	6/6/71	Oak Hill Cemetery	Lonaconing	A	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	JUN 9 1971	Vernon R. Randall

VR A15 (4)
45M - 1-69

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08206

CERTIFICATE OF DEATH

08208

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Lewis	John	Bridges	JUNE 7 1971	7.55 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	May 19,1902	69 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Miners Hospital	Miner	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Mt. Savage	YES ☒ NO ☐	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John Lewis Bridges			Nettie Elliott		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	1919-1920	220-10-2328	Mrs. Lewis Bridges, Mt. Savage, Md. Box 307	21545

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of the Lung (Adenocarcinoma) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs +
1621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
NONE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
✓	✓		✓

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
✓	✓	✓

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	✓	✓			

22a. **I certify** that (I) (this hospital) attended the deceased from JUNE, 1969, to 6-7, 1971, that (I) (we) last saw the deceased alive on 6-6 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Martin M. Rothstein		☒	☐	☐	6-7-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MARTIN M. ROTHSTEIN M.D.	48 BROADWAY - FROSTBURG MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 10,1971	Porter Cemetery	Eckhart, Allegany Co., Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harvey H. Zeigler, Hyndman, pa. 15545	JUN 14 1971	Vernon B. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1 69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08207 08209

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
THOMAS	GEORGE	BROOKS	06 09 71	12:45

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	08 18 09	61 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	MARYLAND STATE ROADS	DEPT. -INSPEC.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	539 GREENE STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOSEPH		BROOKS	(LAVIN) CATHERINE		BROOKS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	214-05-6917	SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) CIRRHOSIS OF THE LIVER.
DUE TO, OR AS A CONSEQUENCE OF
(c)

5719

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH [ ] OR CONTRIBUTING [ ]	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 5-24, 1971, to 6-9, 1971, that (I) (~~we~~) last saw the deceased alive on 6-8 1971, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
M. Kaufman M.D.		X	[ ]	[ ]	6/9/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
M. KAUFMAN, M.D.	924 SETON DR., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/11/71	St. Mary's Cemetery	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George GEORGE FUNERAL HOME, 202 GREENE ST., CUMB., MD.	JUN 14 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, or removal, and in any event, within 72 haurs after death.

VR A15 (4)
25m-1/70

THOMAS GEORGE BROOKS 06 09 71 12:45

MALE WHITE 08 15 09 61

MARYLAND U.S.A. ALLEGANY COUNTY,

CUMBERLAND SACRED HEART HOSPITAL MARYLAND STATE HEALTH DEPT.-1 SPEC.

MARYLAND ALLEGANY CUMBERLAND X 329 GREENE STREET

JOSEPH BROOKS (LAVIN) CATHERINE BROOKS

NO 214-05-6917 SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502

M. KAUFMAN, M.D. 924 SETON DR., CUMBERLAND, MD. 21502

GEORGE FUNERAL HOME, 26-26 GREENE ST., CUMB., MD.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08208 — 08210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: ETHEL	Middle: C	Last: BRUCE	2a. DATE OF DEATH: 6 Month 5 Day 71 Year	2b. HOUR: 2:10 M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 4-17-07	6. AGE (In years last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 108 LUTEMAN ROAD		
14. FATHER'S NAME First: WILLIAM	Middle: H	Last: CUNNINGHAM	15. MOTHER'S MAIDEN NAME First: ROSA	Middle:	Last: MAC KENZIE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. (Address)				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral hemorrhage due to massive cerebral infarction	7 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic cardiovascular disease	10 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Hypertensive cardiovascular disease	10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS DR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from ____, 19 56, to 6/5, 19 71, that (I) (we) (last) saw the deceased alive on 6/5 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: S.G. Weisman M.D.	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 6/5/71
22d. PHYSICIAN'S NAME (Type): DR. S.G. WEISMAN	22e. ADDRESS: CUMBERLAND, MD. 21502				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/7/71	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.	23d. LOCATION (City or Town) (County) (State): Cumb. Allegany Md.	
24. FUNERAL DIRECTOR: Louis Stein Inc.	ADDRESS: Cumb. Md.	25a. REC'D BY REGISTRAR DATE: JUN 11 1971	25b. REGISTRAR'S SIGNATURE: Vernon G. Randall	

VR A (5-14) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

08209

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08211

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED XX Month Day Year	2b. HOUR
MILNOR	ROBERTS	BRUCE	June 8, 1971	10p M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 19	2d. HOUR
Male	White	3/9/ 1906	65 YRS.					June 9, 1971	9p M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
CUMBERLAND MD.	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND MD.	108 LUTHMAN ROAD	RETIRED ACCOUNTANT.	KS-TIRECO.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	108 LUTHMAN ROAD

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM	M	BRUCE SR.	ELEANOR		ROBERTS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES	WW II		RICHARD J. BRUCE SR. CUMBERLAND MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) GUNSHOT OF HEAD — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES

955 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) (SELF INFLICTED)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: June 9, 1971

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	6/12/71	ROSE HILL CEM.	CUMBERLAND ALLEGANY MD.

24. FUNERAL DIRECTOR ADDRESS: Louis Stein Inc. Cumberland Md.

25a. RECD BY REGISTRAR DATE: JUN 14 1971

25b. REGISTRAR'S SIGNATURE: Vernon G. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Copies 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9) 10M - 1/69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08210 — 08212

1. DECEASED-NAME (Type or Print)	First: Sandra	Middle: Virginia	Last: Clay	2a. DATE KNOWN ☐ OF ESTI-MATED ☐	Month: 6	Day: 5	Year: 19 71
2b. HOUR	1:50 M						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD	2d. HOUR
Female	White	3/10/51	20 YRS.			Month 6 Day 5 Year 19 71	1:50 M

7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH Allegany Md.	
10. CITY OR TOWN OF DEATH Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA--Sacred Heart Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) State Road Employee	12b. KIND OF BUSINESS OR INDUSTRY	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Allegany	13c. CITY OR TOWN Midland	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER Dans Rock Road

14. FATHER'S NAME	First: Richard	Middle	Last: Clay	15. MOTHER'S MAIDEN NAME	First: Edna	Middle	Last: Myers

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT "Mother"	ADDRESS Mrs.Alvin Lease Midland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ruptured Lungs — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Crushed Chest — "

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1:00 P.M. 6-5-71	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Passenger in;One Car Collision	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 2 Miles West of LaVale Rt.#40	21f. LOCATION Street or R.F.D. No. / City or Town / County / State LaVale, Allegany, Maryland	

22a. **I certify** that I taak charge af the remains described abave, held an Autapsy ☒, Inspection ☒, Inquiry ☒, and in my apinian death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED June 5, 1971

ADDRESS(Street, city, town, or county) Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/8/71	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or Town) Cumberland (County) A. (State) Md	
24. FUNERAL DIRECTOR George Eichhorn	ADDRESS Lonaconing, Md.	25a. REC'D BY REGISTRAR DATE JUN 11 1971	25b. REGISTRAR'S SIGNATURE Vernon R. Randall	

VR A15ME (5) 10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08211

CERTIFICATE OF DEATH

08213

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
ANTHONY	WAYNE	COZAD	JUNE	4	71	5:30 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	OCT. 21, 1889	81 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
WEST VIRGINIA	U.S.A.	WIDOWED [X]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMB ERLAND	ALLEGANY CO. INFIRMARY	TELEGRAPHER-RETIRED	RAILROAD

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [ ] NO [ ]	BLOOMS TRAILOR COURT

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JEFFERSON		COZAD	LYDIA		HELMS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
UNKNOWN		705-05-8124	RECORDS	ALLEGANY CO. INFIRMARY BOX 599

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	acute CVA	2 days.
DUE TO, OR AS A CONSEQUENCE OF (b)	Chr. A.S. H D	years.
DUE TO, OR AS A CONSEQUENCE OF (c)	Generalized arteriosclerosis	years

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from MAY 10, 1971 to JUNE 4, 1971, that (I) (we) last saw the deceased alive on _____ 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John A Tepper	MD	[X]	[ ]	[ ]	6-5-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John A Tepper	MEMORIAL HOSPITAL, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 7, 1971	Hillcrest Burial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli	Cumberland, Md.	JUN 9 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (11-68)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

08212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08214

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED Month	Day	Year	2b. HOUR
Bernard	DeSales	Creegan	6	17	1971	4p M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
Male	White	June 2, 1903	68 YRS.					6	17	1971	4p M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	DOA- Memorial Hospital	Retired Celanese Corp of America	Emp.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Allegany	Cumberland	YES [X] NO [ ]	437 Henderson Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Edward	F	Creegan	Lucy	M	Simpson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	214-07-3399	Mrs. Ruth M. Creegan	437 Henderson Ave Cumberland, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Manth, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X] Inquiry [X], and in my opinion death resulted from: Natural causes [XX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]

22b. DATE SIGNED June 17, 1971

ADDRESS (Street, city, town) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/21/71	St. Mary's Catholic Cem.	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md 21502	JUN 22 1971	Vernon O. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only Item 5 is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

08213

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08215

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year	2b. HOUR
Edith	L.	Crites	6-20-71 19	8 p M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Female	White	1/14/04	67 YRS.					June 20, 1971 19	8:30p M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED XX DIVORCED [ ]	9. COUNTY OF DEATH
Md.	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Rt.# 3 Bedford Rd.	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES [ ] NO [X]	Rt. # 3, Bedford Rd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles	W.	Frantz	Annie	L.	Burkett

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	214-07-0341	D Betty Caporossi	Bedford Rdd Cumberland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b) CORONARY SCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [XX]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED June 20, 1971

ADDRESS (Street, city, town) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/23/71	Hillcrest Burial Park	Cumberland Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William G. Kight	Cumberland, Md.	JUN 28 1971	Vernon R. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 5 may be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M. 1.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08214

CERTIFICATE OF DEATH

08216

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
KATHRYN	(Jack)	DEAN	6 22 71	1:05 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	6-28-88	82 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W. VA.	USA	WIDOWED [X]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	208 MARYLAND AVE.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ROBERT	W	JACK	SARAH	Elizabeth	IDELMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214-05-6131	MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinoma Cervix	7 years
DUE TO, OR AS A CONSEQUENCE OF (b)	Bilateral Hydronephrosis	6 Mon.
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 180X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
1966	Ca Cervix	YES [ ] NO [X]	

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner)	UNDERLYING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 66, to June 22, 19 71, that (I) (we) last saw the deceased olive on _____ 19 ___, and that in (my) (our) opinion death occurred on the date and hour ond from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
W.R. Hodges M.D.	M.D.	[X]	[ ]	[ ]	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. R. HODGES	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	6/25/1971	Sunset Memorial Park	Nr. Cumberland	Alleg	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Hafer Funeral Service	230 Balto Ave. Cumberland, Md	JUN 25 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08215 — 08217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: FRANK	Middle: Allen	Lost: ~~Deffinbaugh~~ DEFFENBAUGH	2a. DATE OF DEATH Month: 06	Day: 08	Year: 71
2b. HOUR	7:20 P.M.					
3. SEX	MALE	4. RACE	WHITE	5. DATE OF BIRTH	10-31-1889	6. AGE (In years last birthday) 81 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.				
7a. BIRTHPLACE (State or foreign country)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Clerk	12b. KIND OF BUSINESS OR INDUSTRY: Railroad
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MARYLAND	13b. COUNTY	ALLEGANY	13c. CITY OR TOWN	CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER	727 MONTGOMERY AVE					
14. FATHER'S NAME First	BENJAMIN	Middle		Lost	~~Deffinbaugh~~ DEFFENBAUGH	
15. MOTHER'S MAIDEN NAME First	SARAH	Middle		Lost	MITCHEL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.	705-10-7911	17. INFORMANT	MEMORIALHOSPITAL	Address: CUMBERLAND, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis (Left) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS DR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I certify that (I) (this hospital) attended the deceased from 4/15/71, 19____, to 6/8/71, 19____, that (I) ~~(we)~~ last saw the deceased alive on 6/8/71 19____, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: R. J. Williams DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 6/10/71
22d. PHYSICIAN'S NAME (Type): R. J. WILLIAMS M.D.
22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	6/10/71	Hillcrest Burial Park	Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
Philip B. Wendt	121 Memorial Ave., Cumb., Md.	JUN 14 1971	Vernon G. Randall	

VR A15 (7) 25m-1170

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08216 — 08218

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: FLORENCE	Middle: C.	Last: DEITRICH ~~DETRICK~~	2a. DATE OF DEATH: Month 6 Day 16 Year 71	2b. HOUR: 9:50A
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 1-31-94	6. AGE (In years last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 32 HOWARD ST.	
14. FATHER'S NAME First: William	Middle	Last: Warwick	15. MOTHER'S MAIDEN NAME First: Mary	Middle: A.	Last: Frederick
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of The Stomach — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1½ years
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Peripheral Arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING ☐ CAUSE OF DEATH ☐ OR CONTRIBUTING ☐
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19 70, to 6/16, 19 71, that (I) (we) last saw the deceased alive on 6/16 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 6/17/71

22d. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN — 22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/19/71	St. Patrick's Cem.	Cumb. Allegany Md.

24. FUNERAL DIRECTOR: Louis Stein Inc. — ADDRESS: Cumb. Md.
25a. REC'D BY REGISTRAR DATE: JUN 22 1971 — 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08217 08219

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
GENEVA	ROZELLA	DEVORE	06 23 71	8:20 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	4-1-16	55 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	UNITED STATES	NEVER MARRIED [X]	ALLEGANY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	TWISTING	CELANESE

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	ELLERSLIE	YES [X] NO [ ]	BOX 142

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
DAVID		DEVORE	LOWERY	MARY	DEVORE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	214 07 1863	HOSPITAL RECORD, 900 SETON DR., CUMBERLAND, M

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PULMONARY EMBOLIZATION, MASSIVE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) PHLEBOTHROMBOSIS, RIGHT LEG UPPER PART

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c) ADMITTED WITH CELLULITIS LEFT LEG

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (1): DIABETES MELLITUS AND EXOGENOUS OBESITY

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	YES

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medicol exominer)	UNDERLYING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 6-11, 19 71, to 6-23, 19 71, that (I) (~~me~~) last saw the deceased alive on 6-23 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Morton L Kaufman MD	MD	[X]	[ ]	[ ]	6-24-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
M. KAUFMAN, M.D.	924 SETON DR., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 27, 1971	Porter Cemetery	Hyndman, Pa. RD#1 Bedford Co.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ZIEGLER'S FUNERAL HOME, HYNDMAN, PENNA.	JUL 1 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08218 — 08220

FOR STATE HEALTH DEPT.

1. DECEASED-NAME (Type or Print)	First	Middle	Last
	ORVILLE	HAMMAR	DIXON

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month 6 Day 14 Year 71 19 — 2b. HOUR 5 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
MALE	CAU.	9/25/13	57 YRS.				

2c. DATE PRONOUNCED DEAD Month June Day 14 Year 1971 19 — 2d. HOUR 6 p M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Penna.	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	D.O.A. Memorial Hosp.	Brakeman	W.Md. Railroad

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W. Va.	Mineral	Ridgeley	YES [X] NO [ ]	8 Blocker St. Ridgeley, W.V

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Jackson	Ray	Dixon	Ida	Mae	Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No,	236-01-9681	Mrs. Marguerite Dixon	Ridgeley. W.VA. 8 Blocker St.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	--
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [XX], and in my opinion death resulted from: Natural causes [XX] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]

22b. DATE SIGNED June 14, 1971

ADDRESS(Street, city, town, or county) Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/17/71	Hillcrest Burial Park	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George	Cumberland, Md.	JUN 17 1971	Vernon R. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 with the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
10M - 1/69

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08219 08221

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First	Middle	Last						2a. DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b. HOUR
Thomas	Francis	Duffy						X / ☐	6-23-71		19	1:30 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN	2c. DATE PRONOUNCED DEAD	Month	Day	Year	2d. HOUR
Male	White	7-29-29	41 YRS.						June 23,	1971	19	1:30 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	9. COUNTY OF DEATH	
New Jersey	USA		Allegany	Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Miners Hospital--DOA	College Professor	Schools

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Frostburg	YES X / NO ☐	236 East Main

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last		
John J. Duffy	Julia		McGough
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes / Korean	157-18-0706	Mrs. Noreen Duffy	236 E. Main

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Asphyxiation	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Hanging	
DUE TO, OR AS A CONSEQUENCE OF (c)	(Self inflicted)	

953.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES X / NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection XX Inquiry XX and in my opinian death resulted from: Natural causes ☐, Accident ☐, Suicide XX, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X
22b. DATE SIGNED June 23, 1971
ADDRESS(Street, city, town, or county) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	6-26-71	Holy Cross Cemetery	Mays Landing	Atlantic N.J

24. FUNERAL DIRECTOR Hafer-Sowers Funeral Home Gary L. Beachy	ADDRESS 60 West Main Frostburg Md.	25a. REC'D BY REGISTRAR DATE JUN 28 1971	25b. REGISTRAR'S SIGNATURE Vernon R. Randall	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DHS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08220

08222

1. DECEASED-NAME (Type or print): First LULA; Middle; Last EFFLAND
2a. DATE OF DEATH: Month JUNE; Day 23; Year 1971
2b. HOUR: 515 AM
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: APRIL 4, 1888
6. AGE (In years last birthday): 83 YRS.
IF UNDER 1 YEAR: MONTHS; DAYS
IF UNDER 24 HRS.: HOURS; MIN.
7a. BIRTHPLACE (State or foreign country): PENNA.
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): CUMBERLAND NURSING HOME
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 527 PEARRE AVE
14. FATHER'S NAME: First SAMUEL; Middle D; Last KINSER
15. MOTHER'S MAIDEN NAME: First VIRGINIA; Middle; Last MCELFISH
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 214-05-8982
17. INFORMANT: Address JOHN EFFLAND, JR., FREDERICK, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO, OR AS A CONSEQUENCE OF (b): Acute Renal Failure
DUE TO, OR AS A CONSEQUENCE OF (c): Advanced Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
7409
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Advanced cerebral arteriosclerosis
19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from 1960, 19____, to 6-23, 1971, that (I) (we) last saw the deceased alive on 6-16 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William P James M.D. DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 6/24/71
22d. PHYSICIAN'S NAME (Type): William P. James
22e. ADDRESS: 441 N. Centre St, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 6/26/71
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md

24. FUNERAL DIRECTOR: William L Kight
ADDRESS: Cumberland, Md
25a. REC'D BY REGISTRAR DATE: JUN 28 1971
25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

08221

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08223

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year	2b. HOUR
NETTIE		EVANS	JUNE 21, 1971	3:00AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
FEMALE	WHITE	10-1-1914	56 YRS.					JUNE 21, 1971	3:00AM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH
MD.	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	D.O.A. MINERS HOSPITAL	HOUSEWIFE	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER
MD.	ALLEGANY	FROSTBURG		RT 1, BORDON SHAFT

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
SAMUEL	J.	HARTMAN	ANNIE		QUYN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO		MRS. CHARLES SHAFFER, RT 1 BORDON SHAFT FROSTBURG, MD. 21532

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED JUNE 21, 1971

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	6-23-1971	FROSTBURG MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST SR. FROSTBURG, MD. 21532	JUN 28 1971	Vernon G. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if circumstances are not necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 with the State Department of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMD. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1

08222

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08224

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
KATHERINE		FATKIN	JUNE 28, 1971	2:00 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
FEMALE	WHITE	AUG. 30, 1899	71 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	MINERS HOSPITAL	HOUSEWIFE	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CARLOS		CARLOS R.F.D. FROSTBURG, MD.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
HENRY		HITCHINS	MARY		STEENE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4123
IMMEDIATE CAUSE (a) Myocardial Ischemia
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: weeks / years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Repeated CVA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 1965, to June 28, 1971, that (I) (we) last saw the deceased alive on June 27 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	MD	[X]	[ ]	[ ]	7-1-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
LESLIE R. MILES, JR., M.D.	STATE ST., LONACONING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	6/30/71	FROSTBURG MEM. PARK	FROSTBURG, ALLEGANY, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
MARILOU M. SOWERS, HAFER-SOWERS FUNERAD HOME, 60 W. MAIN, FROSTBURG	JUL 6 1971	Vernon G. Randall

VR A15 (4)
45M - 1/69

1

08223

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08225

1. DECEASED-NAME (Type or print) First: WALTER Middle: J. Last: FUNKHOUSER	2a. DATE OF DEATH Month 06 Day 08 Year 71	2b. HOUR A 2:15 M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 12 08 94	6. AGE (In years last birthday) 76 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY COUNTY, Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: Alleg.	13c. CITY OR TOWN: LUKE	13d. INSIDE CITY LIMITS? YES [XX] NO [ ]
13e. STREET AND NUMBER: 373 NEVISON AVENUE			
14. FATHER'S NAME First: SAMUEL Middle: Last: FUNKHOUSER	15. MOTHER'S MAIDEN NAME First: (WILKINS) VICTORIA Middle: Last: FUNKHOUSER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 216-05-9635	17. INFORMANT Address: SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502	

52 01 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinomatosis of the brain and lungs	1 year
DUE TO, OR AS A CONSEQUENCE OF (b)	Carcinoma of the lung	1 year
DUE TO, OR AS A CONSEQUENCE OF (c)		

1621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Myocardial ischemia due to arteriosclerotic heart disease c̄ an infarction 2/69

X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 60, to 6/8, 19 71, that (I) (we) last saw the deceased alive on 6/7 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] for DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 6/8/71	
22d. PHYSICIAN'S NAME (Type): S.G. WEISMAN, M.D.	22e. ADDRESS: 59 GREENE ST., CUMB., MD. 21502	

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/10/71	23c. NAME OF CEMETERY OR CREMATORY: Philos	23d. LOCATION (City or Town) (County) (State): Westernport-Allegany-Md.
24. FUNERAL DIRECTOR: E. J. Boal ADDRESS: BOAL FUNERAL HOME, 111 CHURCH ST., WESTERNPORT, MD.	25a. REC'D BY REGISTRAR DATE: JUN 14 1971	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M (VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08224 08226

1. DECEASED-NAME (Type or print): First CLARA Middle SARAH Last GILFORD
2a. DATE OF DEATH: Month 06 Day 29 Year 71
2b. HOUR: 11:10 A.M.
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: 01 11 94
6. AGE (In years last birthday): 77 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSE WIFE
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 1038 SHADES LANE
14. FATHER'S NAME: First WILLIAM Middle Last MATTHEWS
15. MOTHER'S MAIDEN NAME: First (LINDNER) ANNA Middle Last MATTHEWS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
16b. SOCIAL SECURITY NO.: 219 14 7002
17. INFORMANT: PATIENT'S HOSPITAL CHART Address: 900 SETON DRIVE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): SEPTIC EMBOLIZATION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: DAYS
DUE TO, OR AS A CONSEQUENCE OF (b): SEPTICEMIA — DAYS
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
0389

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
ANEMIA ; ARTERIOSCLEROTIC HEART DISEASE

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21a. ACCIDENT WAS (If either, notify medical examiner): UNDERLYING CAUSE OF DEATH ☐ OR CONTRIBUTING ☐
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from JUNE 10, 1971, to JUNE 29, 1971, that (I) (~~we~~) last saw the deceased alive on JUNE 29 1971, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Renato N Espina DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 30 June 71
22d. PHYSICIAN'S NAME (Type): RENATO ESPINA, M.D.
22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: July 2, 1971
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Rfd #3 Cumberland Allegany MD.
24. FUNERAL DIRECTOR: MERRITT
ADDRESS: SILCOX, FUNERAL HOME, 404 DECATUR ST., CUMB.,
25a. RECD BY REGISTRAR: MD. DATE JUL 2 1971
25b. REGISTRAR'S SIGNATURE: Vernon A. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4) 25m-1/70

CLARA	SARAH	GILFORD	05	2	71	
FEMALE	WHITE	01 12			72	
PENNSYLVANIA	U.S.A.	X		ALLEGANY		
CUMBERLAND	SACRED HEART HOSPITAL					
MARYLAND	ALLEGANY	CUMBERLAND	X	1039 SHADES LANE		
VILLIAM	MATTHEWS	(LINDNER) ANNA		MATTHEWS		

215 IN 7002 PATIENT'S HOSPITAL CHART 900 SETON DRIVE
CUMBERLAND, MD.

RENATO ESPINA, M.D. 912 SETON DRIVE, CUMBERLAND, MD.

SILCOX, FUNERAL HOME, 900 DECATUR ST., CUMB., MD.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08225 — 08227

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
LENA		GLANTZER	6	7	71	1:30P

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	WHITE	8-17-06	64 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MD.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND,	MEMORIAL HOSPITAL	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	953 GLENWOOD ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ULYSSUS,		MC COY	EMMA		LYNCH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No NONE		MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Resp Arrest — 3

DUE TO, OR AS A CONSEQUENCE OF: (b) Art. Sclerosis

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (c)

4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
			Cumberland	Allegany	

22a. **I certify** that (I) (this hospital) attended the deceased from 4/7/71, 19____, to 6/7/71, 19____, that (I) ~~(we)~~ last saw the deceased alive on 6/7/71 19____, and that in (my) ~~(our)~~ apinian death occured on the date and haur and from the causes stated above, (I) ~~(we)~~ ~~did~~ (did nat) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
R J Williams	MD	☒	☐	☐	6/6/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. WILLIAMS	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 11,1971	St. Luke's Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JUN 11 1971	Vernon R. Randall

VR A 54 (25m-1/70)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08226

08228

1. DECEASED-NAME (Type or print): First DAISY; Middle D.; Last GODSEY

2a. DATE OF DEATH: Month 06 - Day 15 Year 71

2b. HOUR: 2:10 PM

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH: JULY 31, 1902

6. AGE (In years last birthday): 68 YRS.

IF UNDER 1 YEAR: MONTHS; DAYS

IF UNDER 24 HRS.: HOURS; MIN

7a. BIRTHPLACE (State or foreign country): VIRGINIA

7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: ALLEGANY COUNTY Md.

10. CITY OR TOWN OF DEATH: CUMBERLAND

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP.

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND

13b. COUNTY: ALLEGANY

13c. CITY OR TOWN: CUMBERLAND

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET AND NUMBER: 103 SHAMROCK ROAD, BEL AIR

14. FATHER'S NAME First WILLIAM; Middle; Last DENTON

15. MOTHER'S MAIDEN NAME First LULA; Middle; Last MILLS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 244 74 7437

17. INFORMANT: HOSPITAL RECORD, Address 900 SETON DRIVE, CUMBERLAND, MARYLAND 21502

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart failure

DUE TO, OR AS A CONSEQUENCE OF (b): Obstructive lung disease. (Emphysema)

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify thot (I) (this haspital) attended the deceased from _____, 19____, to _____, 19____, thot (I) (we) lost saw the deceased alive an _____ 19____, and that in (my) (our) opinion deoth occurred on the date and haur and fram the causes stoted above, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE: C J Vincent MD DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 6/16/1971

22d. PHYSICIAN'S NAME (Type): CLARENCE J. VINCENT, M.D.

22e. ADDRESS: 924 SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: June 18, 1971

23c. NAME OF CEMETERY OR CREMATORY: Hillside Cemetery

23d. LOCATION (City or Town) (County) (State): Laurinburg Scotland N.C.

24. FUNERAL DIRECTOR: John E. Hafer

ADDRESS: HAFER'S FUNERAL HOME, 230' BALTIMORE AVENUE CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE: JUN 18 1971

25b. REGISTRAR'S SIGNATURE: Vernon E. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

CLARENCE J. VINCENT, M.D. 924 SETON DRIVE, CUMBERLAND, MD. 21502

OFFER'S FUNERAL HOME, 280 BALTIMORE AVENUE
CUMBERLAND, MD.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08227 08229

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: ANDREW	Middle: VERNON	Last: GRAYSON	2a. DATE OF DEATH: 06 Month 27 Day 71 Year	2b. HOUR: M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 10-18-17	6. AGE (In years last birthday): 53 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): W. VA.	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY, Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): FIREMAN	12b. KIND OF BUSINESS OR INDUSTRY: B&O RR			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. VA.	13b. COUNTY: MINERAL	13c. CITY OR TOWN: KEYSER	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 197 ARGYLE ST.		
14. FATHER'S NAME First / Middle / Last: LAWRENCE / / GRAYSON	15. MOTHER'S MAIDEN NAME First / Middle / Last: (TETENBURN) LEONA / / GRAYSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 233 26 1263	17. INFORMANT Address: HOSPITAL CHART, 900 SETON DR., CUMBERLAND, M				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): sepsis
DUE TO, OR AS A CONSEQUENCE OF (b): myocardial infarct
DUE TO, OR AS A CONSEQUENCE OF (c): lymphosarcoma.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: c. 2 wks. / immediate / from Oct. 70
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Prior hx of stroke, central vascular disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) UNDERLYING [ ] CAUSE OF DEATH [ ]	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (this hospital) attended the deceased from 6-15, 19 71, to 6-27, 19 71, that (I) (we) last saw the deceased alive on 6-27 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ] 22c. DATE SIGNED: 29 June 71

22d. PHYSICIAN'S NAME (Type): E.W. CAMPBELL, M.D. 22e. ADDRESS: 912 SETON DR., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 30 June 71	23c. NAME OF CEMETERY OR CREMATORY: Queens Point	23d. LOCATION (City or Town) (County) (State): Keyser Mineral W.Va.	
24. FUNERAL DIRECTOR: [signature]	ADDRESS: ROTRUCK FUNERAL HOME, 85 S. MAIN ST., KEYSER, W.VA.	25a. REC'D BY REGISTRAR DATE: JUL 6 1971	25b. REGISTRAR'S SIGNATURE: Vernon O. Randall	

DHMH-16 1/71 3AM
(VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08228 08230

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MARY	HATTIE	E GRIMES	6 6 71	10:25 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	7-9-01	69 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH
PENNA.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	SEAMSTRESS	CLOTHING

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES X NO	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND		721 OLDTOWN RD.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
SCOTT		WEAVERLING	SADIE		MALLOTT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	218 12 5914	MEMORIAL HOSPITAL	CUMBERLAND, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days / years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING / DR CONTRIBUTING / CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. I certify that (I) (this hospital) attended the deceased from June 7, 19 71, to 6/6, 19 71, thot (I) (we) last saw the deceased olive on 6/6 19 71, ond thot in (my) (our) opinion deoth occurred on the dote and hour ond from the causes stated obave, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	MD	X			6/8/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. B.SCHINDLER-PA	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	6/9/71	HILLCREST BURIAL PARK	CUMBERLAND, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	JUN 14 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets 1 and 2 and in any event, within 72 hours after death. should be filed with the State Dept. of Health priar to burial, cremation, ar removal,

VR A15 (4) 25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08229 08231

1. DECEASED-NAME (Type or print) First	Middle	Last	2o. DATE OF DEATH Month Day Year	2b. HOUR
JAMES	THOMAS	GUY	06 23 71	8:26PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	10-23-97	73 YRS.		

7o. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	UNITED STATES	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	Foreman	WESTVACO

13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	WESTERNPORT	YES [X] NO [ ]	415 MARYLAND AVE.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOSEPH		GUY	PRESLEY	MARY	GUY

16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO		216 05 9747	HOSPITAL RECORD, 900 SETON DR., CUMBERLAND, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ventricular fibrilation

DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF (c) Coronary insufficency.

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Urinary retention, Urethral manipulation

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20o. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS (If either, natity medical examiner)	UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospitol) attended the deceased from 6-2-3, 1971, to 6-23, 1971, thot (I) (we) lost saw the deceosed olive on 6-23 1971, and thot in (my) (our) opinion deoth occurred on the date and hour ond from the causes stoted obove, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED.
Valdes	M.D.	[✓]	[ ]	[ ]	6-24-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
J. VALDES, M.D.	ALGONQUIN HOTEL, CUMBERLAND, MD.

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/26/71	Philos	Westernport, Alle. Md.

24. FUNERAL DIRECTOR	ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
E.S. Boal BOAL'S FUNERAL HOME,	111 CHURCH ST., WESTERNPORT MD.	JUN 28 1971	Vernon A. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be forwarded to the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

08230

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08232

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN / ESTIMATED OF DEATH	Month Day Year	2b. HOUR
Lester	Whitfield	Harvey		June 28 1971	6P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month Day Year	2d. HOUR
Male	White	May 10,1914	57 YRS.			June 28 19 71	6P M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Md.	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	D.O.A. Memorial Hospital	Mechanic	Automobile

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W.Va.	Mineral	Ridgeley	YES [X] NO [ ]	Millerdale

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Benjamin Harvey	Fanny Walters

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Mrs. Romona Reeder, Ridgeley, W.Va.-Wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — ***

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4169

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town, or county) Cumberland, Md.

22b. DATE SIGNED June 28, 1971

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	July 1, 1971	Davis Memorial Cemetery	Cumberland, Alleg. Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JUL 1 1971	Vernon R. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give (Pages 1) and 2 with the State Department of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form NMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
1DM - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08231

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	CHARLES	Middle E.	Last HAYES
2a. DATE OF DEATH Month Day Year	JUNE 21, 1971		2b. HOUR 12:15 P.M.
3. SEX	MALE		
4. RACE	WHITE		
5. DATE OF BIRTH	4-12-1895		
6. AGE (In years last birthday)	76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country)	MD.		
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐			
9. COUNTY OF DEATH	ALLEGANY		Md.
10. CITY OR TOWN OF DEATH	FROSTBURG		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	MINERS HOSPITAL		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	PLUMMER		
12b. KIND OF BUSINESS OR INDUSTRY	SELF		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MD.		
13b. COUNTY	ALLEGANY		
13c. CITY OR TOWN	FROSTBURG		
13d. INSIDE CITY LIMITS? YES ☒ NO ☐			
13e. STREET AND NUMBER	W. MAIN ST.		GUNTER HOTEL
14. FATHER'S NAME First	GEORGE	Middle M.	Last HAYES
15. MOTHER'S MAIDEN NAME First	AMELIA	Middle	Last SONNENBERG
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	YES	(If yes give wor or dates of service) W.W. 1	
16b. SOCIAL SECURITY NO.	220-16-7028		
17. INFORMANT Address	LAWRENCE HAYES, NEW KENSINGTON, PA.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anemia - due to Chronic Renal Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO, OR AS A CONSEQUENCE OF (b) ACVD - advanced — 15 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 6-14, 1971, to 6-21, 1971, that (I) (we) last saw the deceased alive on 6-20 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Martin M. Rothstein M.D.	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED 6/24/71
22d. PHYSICIAN'S NAME (Type)	MARTIN M. ROTHSTEIN, M.D.	22e. ADDRESS	48 BROADWAY, FROSTBURG, MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
BURIAL	6-23-1971	FROSTBURG MEMORIAL PARK	FROSTBURG, MD.	
24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
JOSEPH R. DURST SR.	FROSTBURG, MD. 21532	JUN 28 1971	Vernon G. Randall	

VR A15 (4) 25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08232

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

1. DECEASED-NAME (Type or print) First: John	Middle: Matthew	Last: Hershiser	2a. DATE OF DEATH Month: 6 Day: 19 Year: 1971	08234	2b. HOUR: M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: October 16, 1907	6. AGE (In years last birthday): 63 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany		Md.
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 301 Baltimore Avenue	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Owner & Operated Goldline Studio	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 121 Bedford Street		
14. FATHER'S NAME First: David	Middle: C.	Last: Hershiser	15. MOTHER'S MAIDEN NAME First: Nettie	Middle: D.	Last: Spidel
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-05-4051	17. INFORMANT: VanHorn T. Hershiser	Address: 301 Baltimore Ave Cumberland, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Thrombosis.	2 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Hypertensive Cardio-Vascular Disease	1 month
DUE TO, OR AS A CONSEQUENCE OF (c)	With Cerebral Vascular Accident.	

4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) UNDERLYING ☐	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. I certify that (I) (this hospital) attended the deceased from May 15, 19 71, to June 19, 19 71, that (I) (we) last saw the deceased alive on June 15, 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: B. M. Schindler DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22c. DATE SIGNED: 6-20-71

22d. PHYSICIAN'S NAME (Type): Dr. Blane M. Schindler, M.D. P.A. 22e. ADDRESS: 43 Greene Street Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/21/71	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION (City or Town): Cumberland,	(County): Allegany,	(State): Md.
24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service,	ADDRESS: Cumberland, Md. 21502	25a. REC'D BY REGISTRAR DATE: JUN 28 1971	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall		

1

08233

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08235

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JAMES	LUTHER	HITE	06 09 71	4:55 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	~~11-29-95~~ xxxxxxxxx 11-29-95	75 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PENNSYLVANIA	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	B&O RR	RAILROAD

13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE	COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
PENNSYLVANIA		HYDNMAN	YES [ ] NO [X]	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ELMER	BRUCE	HITE			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	WW 1	209-09-1990	HOSPITAL REC., 900 SETON DR., CUMBERLAND, MD.	21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	UREMIC POISONING	10 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b)	BILATERAL POLYCYSTIC KIDNEYS	5 YRS
DUE TO, OR AS A CONSEQUENCE OF (c)	ARTERIOSCLEROTIC HEART DISEASE	10 YRS

4409

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

GENERALIZED# ARTERIOSCLEROSIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
	NONE	YES [#] NO [ ]	YES

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
		NONE

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	NONE				

22a. **I certify** that (I) (this hospital) attended the deceased from MAY 31, 19 71, to JUNE 9, 19 71, that (I) (we) last saw the deceased alive on JUNE 9, 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
James J. Hallinan M.D.		# [ ]	[ ]	[ ]	JUNE 11, 1971

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
J. HALLINAN, M.D.	140 ~~[illegible]~~ BEDFORD ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 12, 1971	Hyndman Cemetery	Hyndman, Bedford Co., Pa. 15545

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ZEIGLER, HYNDMAN, PENNSYLVANIA	JUN 16 1971	Vernon P. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

JONES LUTHER WHITE 86 08 71 4:55P

MALE WHITE M-27-65 11-20-05 75

PENNSYLVANIA U.S.A. ALLEGHENY COUNTY,

COUNSELLING SACRED HEART HOSPITAL DEC RR MATLOCK

PENNSYLVANIA HYDNER XR

CLERK BRUCE WHITE

YES 2 205-09-1290 HOSPITAL REC., 900 SETON DR.,COUNSELING, PA.

UREMIC POISONING 10 DAYS

NILATERAL POLYCYSTIC KIDNEYS 5 YRS

INTERSTICLERATIC HEART DISEASE 10 YRS

GENERALIZED ARTERIOSCLEROSIS

NONE A YES

NONE

NONE

JUNE 5, 71 MAY 31, 71 JUNE 5, 71

JUNE 11, 1971

J. HALLINAN, M.D. 100 CHURCH ST, COUNSELING, PA. 21502

Dictated June 22, 1971 Typed by Connie

ZELLER, HYNDMAN, PENNSYLVANIA

1

08234

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08236

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
LESTER	B	HOLLER	6	12	71	6:25 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	8-26-09	61 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W. VA.	UNITED STATES	DIVORCED X	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Helper	Railroad

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES X NO	432 SOUTH STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOSEPH		HOLLER	ELIZABETH		LOUK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes War II	705-09-9757	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Edema congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema arteriosclerotic heart disease

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2509

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) 1 week; (b) 1 year; (c) 5 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH / DR CONTRIBUTING	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from June 7, 1971, to June 12, 1971, that (I) (we) last saw the deceased alive on June 12, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	MD	X			6/12/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. B. SCHINDLER, PA	CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 14, 1971	Sunset Memorial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JUN 16 1971	Vernon O. Ruddle

VR A15-(4)
25m-1170

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

08235

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08237

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form VM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: Effie	Middle: Elizabeth (Huff)	Last: Huff	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month: June Day: 21 Year: 1971	2b. HOUR: 9A M			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Apr. 20, 1889	6. AGE (In years last birthday): 82 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: June Day: 21 Year: 1971	2d. HOUR: 9A M		
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 926 Maryland Ave	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 926 Maryland Ave.			
14. FATHER'S NAME First: John	Middle	Last: Null	15. MOTHER'S MAIDEN NAME First: Clara	Middle	Last: Aberle		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mrs. Ruth Light, Cumberland, Md.	ADDRESS: Daughter				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 4109 CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): Cumberland, Md.

22b. DATE SIGNED: June 21, 1971

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: June 23, 1971	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: JUN 24 1971	25b. REGISTRAR'S SIGNATURE: Homer D. Randall		

VR A15ME (5)
10M - 1/69

14

08236

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08238

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
John	Wesley	Hughes	June 26 1971	9:30 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	12-9-86	84 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Penn.	American	NEVER MARRIED [X]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Lions Manor Nursing Home	Paper Mill Worker	Mechanist

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES [X] NO [ ]	704 Haddon Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Louis		Hughes	Carrie		Mellott

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	War I	221-03-4194	Mrs. Mary L. Smith, Cumberland, Md. Sister

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia due to A.H.D — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Prostatic Hypertrophy

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, natify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this haspital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Wayne C. Spiggle, M.D.	M.D.	[X]	[ ]	[ ]	6/29/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. Wayne C. Spiggle M.D.	Seton Drive, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 30, 1971	Hillcrest Burial Park	Cumberland, Alleg. Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JUL 1 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08237

08239

1. DECEASED-NAME (Type or print): First DOUGLAS; Middle ALLEN; Last IMES

2a. DATE OF DEATH: 06 Month 22 Day 71 Year

2b. HOUR: 4:00 P M

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: 01-29-12

6. AGE (In years last birthday): 59 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN

7a. BIRTHPLACE (State or foreign country): MARYLAND

7b. CITIZEN OF WHAT COUNTRY? UNITED STATES

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: ALLEGANY, Md.

10. CITY OR TOWN OF DEATH: CUMBERLAND,

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND

13b. COUNTY: ALLEGANY

13c. CITY OR TOWN: FROSTBURG

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET AND NUMBER: RT 1, BOX 217

14. FATHER'S NAME First WILLIAM; Middle; Last IMES

15. MOTHER'S MAIDEN NAME First WINGFIELD VIRGINIA; Middle; Last IMES

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO

16b. SOCIAL SECURITY NO. 220-10-8754

17. INFORMANT Address: HOSPITAL CHART, 900 SETON DR., CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTICEMIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: DAYS
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 513X
DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY ABSCESSES
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
(1) RUPTURED GALLBLADDER (2) DIABETIC ACIDOSIS

19a. DATE OF OPERATION: 6/5/71

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: RUPTURED GB

20a. AUTOPSY? YES [X] NO [ ]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21a. ACCIDENT WAS (If either, notify medicol exominer) UNDERLYING CAUSE OF DEATH [ ] OR CONTRIBUTING [ ]

21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 5/31, 19 71, to 6/22, 19 71, that (I) (we) last saw the deceased alive on 6/22 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.

22b. SIGNATURE: [signature], MD DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 23 June 71

22d. PHYSICIAN'S NAME (Type): R.R. ESPINA, M.D.

22e. ADDRESS: 924 SETON DR., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 6-25-71

23c. NAME OF CEMETERY OR CREMATORY: PORTER CEMETERY

23d. LOCATION (City or Town) (County) (State): ECKHART, MD.

24. FUNERAL DIRECTOR ADDRESS: DURST FUNERAL HOME, 57 FROST AVE., FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: JUN 28 1971

25b. REGISTRAR'S SIGNATURE: Vernon G. Rands

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

DOUGLAS ALLEN INES 06 22 71 4:D

MALE WHITE 01-29-12 53

MARYLAND UNITED STATES ALLEGANY,

CUMBERLAND, SACRED HEART HOSPITAL NONE

MARYLAND ALLEGANY FROSTBURG X | RT 1, BOX 217

WILLIAM INES WINCHELD VIRGINIA INES

NO HOSPITAL CHART, 900 SETON DR., CUMBERLAND, MD.

R.F.ESPINA, M.D. 924 SETON DR., CUMBERLAND, MD.

DUNCY FUNERAL HOME, 57 FROST AVE., FROSTBURG, MD.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08238 08240

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Prepared by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: SAVANNAH	Middle: BELLE	Last: JENKINS	2a. DATE OF DEATH Month: 06 Day: 17 Year: 71	2b. HOUR: 1:20 A M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 04/18/88	6. AGE (In years last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XXX	9. COUNTY OF DEATH: ALLEGANY COUNTY, Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: RT. #2, WILLIAMS ROAD, CUMB.		
14. FATHER'S NAME First: JOSEPH	Middle	Last: BRASHEARS	15. MOTHER'S MAIDEN NAME First: (POTTS) ELIZABETH	Middle	Last: BRASHEARS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 218-16-2759	17. INFORMANT: SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,	Address: MD. 2502		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hypostatic Pneumonia	3 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Intestinal Obstruction	10 h
DUE TO, OR AS A CONSEQUENCE OF (c)	Carcinoma of Breast	14 yr

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: E. Mazzocco M.D.	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 6-18-71	
22d. PHYSICIAN'S NAME (Type): E. MAZZOCCO, M.D.	22e. ADDRESS: 912 SETON DRIVE, ; CUMBERLAND, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/19/1971	23c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery	23d. LOCATION (City or Town) (County) (State): Nr. Cumberland Alleg. Md	
24. FUNERAL DIRECTOR: HAFER FUNERAL HOME,	ADDRESS: BALTIMORE AVE., CUMB., MD.	25a. REC'D BY REGISTRAR DATE: JUN 22 1971	25b. REGISTRAR'S SIGNATURE: Vernon O. Randall	

DHMH-16 1/71 30M
(VR A15 (4))

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

08239

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08241

1. DECEASED-NAME (Type or Print) First	Middle	Last
Dubois	Branuin	Jones

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Month June Day 26 Year 71 — 2b. HOUR 11P. M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN.
Male	White	Mar. 27, 1893	78 YRS.				

2c. DATE PRONOUNCED DEAD Month June Day 26, 1971 Year 19 — 2d. HOUR 11p M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. COUNTY OF DEATH
W.Va.	U.S.A.	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Westernport	Route 1	Miner	Coal Mine

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Westernport	YES ☐ NO ☒	Route 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Arthur		Jones	Laura		Edwards

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		218-01-2012	Marshal D. Jones-Westernport, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	--
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED June 26, 1971

ADDRESS (Street, city, town, or county) CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/29/71	Philos	Westernport-Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
E. L. Boal, Westernport, Md.	JUL 1 1971	Vernon O. Randall

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08240

CERTIFICATE OF DEATH

08242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
THEODORE	ALLEN	JONES	6	5	71	10:13A

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
MALE	WHITE	4-2-89	82 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
VA.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	CONDUCTOR	W. MD. R.R.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND		407 BOWLING AVENUE BOWLING GREEN

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
JOHN		JONES	SUSAN		SEE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No,		Mrs. Paul Ross 407 Bowling Ave. Bowling Greene MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Heart failure	Instantly
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Heart Disease	5 years
DUE TO, OR AS A CONSEQUENCE OF (c)	Hypertensive Heart Disease	5 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
Carcinoma of Colon Carcinoma of Prostate

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ (If either, notify medical examiner) UNDERLYING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I **certify** that (I) (this hospital) attended the deceased from ____, 19 66, to 6/5, 19 71, that (I) (we) last saw the deceased alive on 6/ /19 71 and that in (my) (our) apinian death accurred on the date and haur and from the causes stated above (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
H. Weisman	MD	☒	☐	☐	6/5/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. S. G. WEISMAN	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
BURIAL	6/8/71	HILLCREST BURIAL PARK	CUMBERLAND ALLEGANY MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. WAYNE GEORGE CUMBERLAND, MD.	JUN 9 1971	Vernon R. Randall

VR A03(4)
25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08241 08243

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
RUTH	HELEN	KELLY	06 05 71	3:55 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	05-25-22	49 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	UNITED STATES	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	LIBRARIAN	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	LA VALE	YES [X] NO [ ]	1044 NATIONAL HWY.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
THOMAS	M.	MATHEWS	CLITES	MARY	MATHEWS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	218 12 5398	HOSPITAL RECORD, 900 SETON DR., CUMBERLAND, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	sepsis	1wk.
DUE TO, OR AS A CONSEQUENCE OF (b)	pancytopenia	2wks.
DUE TO, OR AS A CONSEQUENCE OF (c)		

284X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
lymphosarcoma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 5 June, 19 71, that (I) (we) last saw the deceased alive on 5 June 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Earl E. Campbell				[X]	7 June 71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
E.W. CAMPBELL, M.D.	912 SETON DR., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/8/71	St. Michaels Cem.	Frostburg Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECEIVED BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
LOUIS STEIN, INC. 117 FREDERICK ST. CUMBERLAND, MD.	JUN 11 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17 08242 08244

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
JOHN	WILEY	KENDALL	06	26	71	7:10PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	11 23 97	73 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PENNA.	U.S.A.	NEVER MARRIED [X]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	COAL DEALER	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
PENNA.		MEYERSDALE	YES [ ] NO [X]	RT. 3, BOX 20

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
SAMUEL	A.	KENDALL	WILEY	MINNIE	EDITH KENDALL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	I & II	210 05 5418	HOSPITAL CHART	900 SETON DRIVE, CUMB., MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE

DUE TO, OR AS A CONSEQUENCE OF

(b) ARTERIOSCLEROTIC HEART DISEASE

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4/23

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING / OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 6- , 19 , to 6-26 , 19 71 , that (I) (we) last saw the deceased alive on 6-26 19 71 , and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
L. M. Gehick		[X]	[ ]	[ ]	6-28-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. M. Gehick	912 SETON DRIVE, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	6/29/71	Homewood Crematory	Pittsburgh All. Pa.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
PRICE'S FUNERAL HOME, 325 MAIN ST., MEYERSDALE, PA	JUL 1 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

08243

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08245

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year	2b. HOUR
C.	Joseph	Koegel	June 25 1971	3 a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	white	May 28 1910	61 YRS.			June 25, 1971	3a M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Cumberland	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital—DOA	Retired	Salesman

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES [X] NO [ ]	209 Emily St.

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Clarence Koegel	Maude Key

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Genevieve Genevieve Koegel, wife same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis — ——

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [XX], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelis M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED June 25, 1971

ADDRESS(Street, city, town, CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	June 28,1971	Hillcrest Burial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Louis Stein, Inc. Cumberland, Maryland	JUN 30 1971	Vernon G. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3-45 if any. be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

1

08244

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08246

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
LELIA	JANE	KUMMER	6 2 71	6:00PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	05-13-89	82 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
OHIO	USA	WIDOWED [X]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSP.		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES [X] NO [ ]	36 TEABERYY LANE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM	H.	PARKS	BRANSON	LIDA	J. PARKS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO		PT.'S. HOSP. RECORD 900 SETON DR. CUMB., MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSES
4339
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) GEN. ARTEMOSCLEROSES
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: DAYS / YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CONGESTIVE HEART FAILURE ; DEBILITY

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—		YES [ ] NO [X]	

21a. ACCIDENT WAS (If either, natify medical examiner) UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 5/25, 19 71, to 6/2, 19 71, that (I) (we) last saw the deceased olive on 6/3 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
R Coffman, MD		[X]	[ ]	[ ]	6/3/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. R.R. ESPINA	924 SETON DRIVE CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	6-5-71	UNION CEMETERY	UHRICHSVILLE, TUSC. OHIO.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
DURST FUNERAL HOME	57 FROST AVE. FROSTBURG MD	JUN 8 1971	Vernon R. Randall

DHMH-16 1/71 30M
(VR A15 (4))

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forworded to the Chief Medicol Examiner's Office along with Form PM3. Page 5 moy be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used os o burioI-transit permit. File pages 1 and 2 with the State Department of Health prior to burioI, cremotion, or removoI, and in any event within 72 hours after deoth.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08245

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08247

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month	Day	Year	2b. HOUR
RICHARD	LEROY	LABER	JUNE	5,	1971	1:00 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
MALE	WHITE	OCT. 18, 1951	19 YRS.					JUNE	5	1971	1:50 P.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	DOA SACRED HEART	PRODUCE DEPT.	MARKET

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	ECKHART		

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
FRED		LABER	MARY	(GUEST)	WINNER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	220-58-0456	MRS. MARY WINNER, FROSTBURG, MD. 21532

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

8190

Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying cause lost.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (o)	RUPTURED LUNGS	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CRUSHED CHEST	"
DUE TO, OR AS A CONSEQUENCE OF (c)	(Auto Accident)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21o. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.)
	1:00 P.M. 6-5-71 19	DRIVER Passenger in one car accident

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Rt.#40 2 miles west of LaVale,	Allegany,	Maryland		

22a. **I certify** that I taak charge of the remains described above, held an Autapsy ☒, Inspection ☒, Inquiry ☐, and in my opinian death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED June 5, 1971

ADDRESS(Street, city, town, or county) RD 9, CUMBERLAND, MD.

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	JUNE 7, 1971	FBG. MEMORIAL PARK	FROSTBURG, MD. 21532

24. FUNERAL DIRECTOR ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	JUN 14 1971	Vernon R. Randall

VR A15ME (5) 10M REV. 1/68

1

08246

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08248

1. DECEASED-NAME (Type or print): First Ara; Middle Bess; Last Langhorst

2a. DATE OF DEATH: Month June; Day 23; Year 1971 @ 1:10 P.M.

2b. HOUR: P.M.

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: 2/5/1887

6. AGE (In years last birthday): 84 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN

7a. BIRTHPLACE (State or foreign country): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S. of America

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Allegany County Md.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Allegany County Infirmary

12a. USUAL OCCUPATION (Kind of work done during mast of working life, even if retired.): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 66 Boone Street

14. FATHER'S NAME: First Calvin; Middle; Last Castle

15. MOTHER'S MAIDEN NAME: First Mary; Middle Elizabeth; Last Twigg

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16b. SOCIAL SECURITY NO.: WA-521370

17. INFORMANT: P.O.Box 599, Cumberland, Md. 21502 Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebro-vascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma — yrs

DUE TO, OR AS A CONSEQUENCE OF (c): Generalized Arteriosclerosis — yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1991

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (this hospital) attended the deceased from July 30, 1969, to June 23, 1971, that (I) (we) last saw the deceased alive an June 22, 1971, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: George M. Simons M.D. DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type): George M. Simons

22e. ADDRESS: Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: June 26, 1971

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City or Town) (County) (Stote): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: JUN 30 1971

25b. REGISTRAR'S SIGNATURE: Vernon G. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (R) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08247

CERTIFICATE OF DEATH

08249

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
PETER	C.	LIPPOLD	6 6 71	12:15PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	2-15-29	42 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W.VA.	USA	NEVER MARRIED [X]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Pipefitter	Railroad

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	24 FIFTH ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN		LIPPOLD	THERESA		MALETICH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1621 Carcinoma Lung
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner)	UNDERLYING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
[ ]	[ ]		

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
[ ] / [ ]					

22a. I **certify** that (I) (this hospital) attended the deceased from June, 1971, to 6/6, 1971, that (I) (we) last saw the deceased alive on 6/6 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	MD PA	[X]	[ ]	[ ]	6/8/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. B.SCHINDLER-PA	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	June 9,1971	St. Mary's Cemetery	Cumberland,Allegany,Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JUN 11 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08248

CERTIFICATE OF DEATH

08250

1. DECEASED-NAME (Type or print) First: Michael Middle: Joseph Last: LITZENBERG

2a. DATE OF DEATH: 6- Month 18 Day 71 Year

2b. HOUR: 11:30 M

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: 6-18-71

6. AGE (In years last birthday) YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS 15 MIN. 4

7a. BIRTHPLACE (State or foreign country): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: ALLEGANY Md.

10. CITY OR TOWN OF DEATH: CUMBERLAND

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND

13b. COUNTY: ALLEGANY

13c. CITY OR TOWN: CRESAPTOWN

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: CONNECTICUT AVE.

14. FATHER'S NAME First: CHARLES Middle: D Last: LITZENBERG

15. MOTHER'S MAIDEN NAME First: JO Middle: ANN Last: HARRISON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 800-01-0750

17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Distress Syndrome — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO, OR AS A CONSEQUENCE OF

(b): Hyaline Membran disease

DUE TO, OR AS A CONSEQUENCE OF

(c): Prematurity - 24 Weeks

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 6/18/71, 19 71, to 6/18/71, 19 71, that (I) (we) last saw the deceased alive on 6/18 19 71, and that in (my) (our) opinion death occurred on the dote ond hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: H. W. Eliason M.D. DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 6/19/71

22d. PHYSICIAN'S NAME (Type): DR. H.W. ELIASON

22e. ADDRESS: CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 6/19/71

23c. NAME OF CEMETERY OR CREMATORY: Philos

23d. LOCATION (City or Town) (County) (State): Westernport, Allegany, Md.

24. FUNERAL DIRECTOR: E. L. Beal

ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: JUN 25 1971

25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

VR A15(d) 25m-1/70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

08249

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08251

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: James	Middle: Melvin	Last: Lockard	2a. DATE KNOWN OF DEATH ESTIMATED: X	Month: 6	Day: 3	Year: 71	2b. HOUR: 12n M		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Aug. 20, 1908	6. AGE (In years last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month June 3; Day 1971 Year		2d. HOUR: 1p M	
7a. BIRTHPLACE (State or foreign country): Pa.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.						
10. CITY OR TOWN OF DEATH: Zihlman	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Zihlman	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Zihlman	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER					
14. FATHER'S NAME First: Martin	Middle: Lockard	Last	15. MOTHER'S MAIDEN NAME First: May lee	Middle	Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes give war or dates of service): Army	16b. SOCIAL SECURITY NO.: 218-09-2125	17. INFORMANT ADDRESS: Mrs. Glenn Dudley--Zihlman						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	--
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I taak charge af the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: June 3, 1971

ADDRESS (Street, city, town, or county): Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: June 6, 1971	23c. NAME OF CEMETERY OR CREMATORY: Porter Cem. Eckhart	23d. LOCATION (City or Town): Allegany, Md.	(County) (State)
24. FUNERAL DIRECTOR: Hafer-Sowers	ADDRESS: 60 West Main St. Frostburg Md. 689-3232	25a. REC'D BY REGISTRAR DATE: JUN 9 1971	25b. REGISTRAR'S SIGNATURE: Vernon O. Randall	

VR A15ME (8) 10M - 1/69

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

08250

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08252

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN X / OF ESTIMATED — Month Day Year	2b. HOUR
HIRAM		LOGSDON	6-16-71 19	1a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month Day Year 19	2d. HOUR
MALE	WHITE	5-14-1875	96 YRS.			June 16, 1971	2a M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MD.	U.S.A.	WIDOWED X	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	MINERS HOSPITAL	FACTORY WORKER	FACTORY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	FROSTBURG	YES X NO	26 DEPOT ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
MOSES		LOGSDON	ANNA		RHINEHART

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	215-20-6191	MISS ALMA LOGSDON	FROSTBURG, MD. 26 DEPOT ST.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — Approximate Interval Between Onset and Death: Hours

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis — --

DUE TO, OR AS A CONSEQUENCE OF (c)

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES / NO X

21a. EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED June 16, 1971

ADDRESS (Street, city, town, or county) Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	6-19-1971	FROSTBURG MEMORIAL PK	FROSTBURG, MD.

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST SR.	FROSTBURG, MD.	JUN 22 1971	[signature]

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Parts 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1

Item#2a,b, 4, FilmG438 7/12/71

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08253

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH / ESTIMATED	2b. HOUR
08251 James	Marquis	Major	Month Doy Year 6/27/1971	10P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD	2d. HOUR
Male	White	4/15/1896	75 YRS.			Month June Day 28 Year 1971	11P M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MD.	USA	WIDOWED X	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Lonaconing, MD.	60 Main St.		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	Allegany	Lonaconing	YES X NO	60 Main St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William		Major	Jessie		Marquis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	War # 1		Miss Cecelia Major (Sister)	Tonawanda, N.Y.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES NO X

21a. EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection XX, Inquiry X, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED XX June 28, 1971

ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/30/1971	Memorial Park	Frostburg, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	JUL 1 1971	Vernon R. Randall

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay in excess of 48 hours must be explained. Give Pages 1, 2 and 3 of this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funerol director. Page 4 should be forwarded to the Chief Medicol Exominer's Office along with Form PM3. Page 5 moy be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used os a burial-transit permit. File pages 1 ond 2 with the State Department of Health prior to burial, cremotion, or removal, ond in ony event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08252 — 08254

1. DECEASED-NAME (Type or Print)	First: James	Middle: Edward	Last: Martin	2a. DATE KNOWN OF DEATH ESTIMATED ☒	Month: June	Doy: 2, 71	Year:	2b. HOUR: 10pM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 7/30/1923	6. AGE (In years last birthday): 47 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month June Day 2 Year 19 71	2d. HOUR: 11pM
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: LaVale	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rt.#55 Midland	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Inspector in Maintence	12b. KIND OF BUSINESS OR INDUSTRY: Bal. & Allegany.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: Allegany Cumberland	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 208 N. Centre St.			
14. FATHER'S NAME: First James / Middle B. / Last Martin	15. MOTHER'S MAIDEN NAME: First Helen / Middle / Last Scharf						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes. (If yes give year or dates of service): WWII + Korea	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mrs. James E. Martin	ADDRESS: Midland Md				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot of Chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO, OR AS A CONSEQUENCE OF
(b): (Self Inflicted)
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if ony, which gove rise to immediate cause (a), stating the underlying couse last. 955X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21o. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Manth, Doy, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED: June 2, 1971
ADDRESS (Street, city, town or county): Cumberland, Maryland

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/5/71	Sunset Memo. Pk.	Cumberland Allegany Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Louis Stein Inc.	Cumb. Md	JUN 11 1971	Vernon R. Randall

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08253

CERTIFICATE OF DEATH

08255

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
WILLIAM	E. (Edgar)	MC CULLOUGH	6 XXX 5 71	8:21A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	10-8-06	64 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MD.	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Retired Employee- Orts Bros Bakery	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	810 MAPLEWOOD LANE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM	A.	MC CULLOUGH	STELLA		WHITE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214-05-8123	MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 ½ yrs.
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis
Myocardial Fibrosis, Auricular Fibrillation — 5½ yrs
DUE TO, OR AS A CONSEQUENCE OF (c)

4/23
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Anasarca, Cardiac Cirhosis, Posterior Myocardial Infarction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS (If either, natify medical examiner) UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port I or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospitol) ottended the deceosed from 12/27/ , 19 66 , to 6/5/ , 19 71 , that (I) (we) last saw the deceased alive on 6/5/ 19 71 , and that in (my) (aur) opinion death accurred on the date ond hour and from the causes stated above, (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
		[✓]	[ ]	[ ]	6/5/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. S. M. JACOBSON	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/7/71	Hillcrest Burial Park	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md 21502	JUN 8 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-(4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08254 08256

1. DECEASED-NAME (Type or print): First EMMA; Middle; Last McKENZIE
2o. DATE OF DEATH: JUNE Month 19 Day 1971 Year
2b. HOUR: M
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: NOVEMBER 7, 1887
6. AGE (In years last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN.
7o. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: FROSTBURG
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MINERS HOSPITAL
12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY:
13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: FROSTBURG
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: ROUTE 1
14. FATHER'S NAME First: ALEXANDER; Middle; Last: CROFT
15. MOTHER'S MAIDEN NAME First: MARGARET; Middle; Last: HETZ
16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 213-09-6380D
17. INFORMANT: MRS. PAUL WILSON, Address: BOX 95 FROSTBURG, MD. RT. 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Hypertensive Cardio-Vascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —
4122
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)
Senility

19o. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20o. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (~~this hospital~~) attended the deceased from 6-15, 19 71, to 6-19, 19 71, thot (I) (~~we~~) last sow the deceosed olive an 6-15 19 71, and that in (my) (~~our~~) opinion deoth occurred on the dote and hour ond from the causes stoted above, (I) (~~we~~) (did) (~~did not~~) view the body after deoth.

22b. SIGNATURE: H. C. Diehl M.D. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 6-19-71
22d. PHYSICIAN'S NAME (Type): DR. H. C. DIEHL, M. D.
22e. ADDRESS: 39 W. MAIN ST., FROSTBURG, MD.

23o. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: JUNE 21, 1971
23c. NAME OF CEMETERY OR CREMATORY: MT. ZION CEMETERY
23d. LOCATION (City or Town) (County) (Stote): GARRETT COUNTY, MD.
24. FUNERAL DIRECTOR: J. R. DURST, ADDRESS: FROSTBURG, MD. 21532
25o. REC'D BY REGISTRAR DATE: JUN 24 1971
25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 25m-1/70

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08255

CERTIFICATE OF DEATH

08257

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Maude	M.	Messman	June 7, 1971	1:45 p. M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	August 1, 1886	84 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	American - USA	WIDOWED X	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland, Md.	Lions Manor Nursing Hm.	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES X NO	106 Independence St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William	H.	Ansel	Hattie		Brant

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		220-52-9686	Office, Lions Manor Nur. Hm.,	Cumb., Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sepsis	2 Wk
DUE TO, OR AS A CONSEQUENCE OF (b)	Pyoderma	2 Wk +
DUE TO, OR AS A CONSEQUENCE OF (c)	Malnutrition	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2699

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Fx hip -

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]				X	6-7-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/10/71	Sunset Memorial Park	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Wilcox-Merritt Funeral Service.	Cumberland, Md 21502	JUN 10 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 1X68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08256 08258

FOR STATE HEALTH DEPT.

1. DECEASED-NAME (Type or Print) First	Middle	Last
DONALD	LEE	MICHAELS

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month JUNE Day 5 Year 1971 — 2b. HOUR 1:00 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
MALE	WHITE	OCT. 20, 1950	20 YRS.				

2c. DATE PRONOUNCED DEAD Month JUNE Day 5 Year 1971 — 2d. HOUR 3:00 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	U. S. MARINE CORP.	

13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG		ROUTE 2, BOX 163

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JAMES	L.	MICHAELS	RACHEL	S.	BEEMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
YES VIETNAM	220-58-1095	JAMES L. MICHAELS, RT. 2, FROSTBURG, MD. BOX 163

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stoting the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	IMMEDIATE CAUSE (a) Ruptured Lungs	Sudden
8191	DUE TO, OR AS A CONSEQUENCE OF (b) Crushed Chest	"
	DUE TO, OR AS A CONSEQUENCE OF (c) (Auto Accident)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
	1:00 P.M. 6-05-71	Passenger Driver in One car Accident

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Rt.#40	2 miles west of LaVale,	Allegany,	Maryland	

22a. **I certify** thot I took charge of the remoins described obove, held an Autopsy [X], Inspection [X], Inquiry [X], ond in my opinion death resulted from: Notural couses [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22b. DATE SIGNED June 5, 1971
ADDRESS(Street, city, town, or county) RD 9, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	JUNE 7, 1971	SUNSET MEMORIAL PARK	CUMBERLAND, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	JUN 14 1971	Vernon R. Randall

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 10M REV. 1/68

1

FOR STATE HEALTH DEPT.

08257

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08259

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: Chester	Middle: Martin	Last: Miller	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month: June Day: 5 Year: 1971	2b. HOUR: 2A M	
3. SEX: Male ~~Female~~	4. RACE: White	5. DATE OF BIRTH: Nov. 11, 1892	6. AGE (In years last birthday): 78 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month: June Day: 5 Year: 1971	2d. HOUR: 3A M
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 923 Virginia Ave.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Celanese Eng.	12b. KIND OF BUSINESS OR INDUSTRY: Textile		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 923 Virginia Ave.	
14. FATHER'S NAME First: William Middle: Miller Last:		15. MOTHER'S MAIDEN NAME First: Addie Middle: ?? Last:			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mr. Chester Miller,	ADDRESS: Cumberland, Md. So n		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Sclerosis — ---
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4100

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus, Hypertensive CV disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Dr. Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county): Cumberland, Md.
22b. DATE SIGNED: June 5, 1971

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: June 8, 1971	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State): Cumberland, Alleg., Md.	
24. FUNERAL DIRECTOR: James F. Scarpelli,	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: JUN 9 1971	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

VR A15ME(15)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08258

CERTIFICATE OF DEATH

08260

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
WILLIS	MARR	MILLER	06	22	71	1:20 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
MALE	WHITE	10-03-84	86 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
TUNNELTON, W.VA.	UNITED STATES		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	KELLY TIRE CO. Inspector	TIRE INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	656 FAYETTE STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ALAN	D.	MILLER	(WRIGHT) CORA	L.	MILLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO		214-05-5547	HOSP. RECORD-900 SETON DRIVE, CUMB. MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 WEEKS

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — 6 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

PERNICIOUS ANEMIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 5-17, 1962, to 6-22, 1971, that (I) (we) last saw the deceased alive on 6-21 1971 and that in (my) (our) opinion death occurred on the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body ofter death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Ralph W. Ballin M.D.		☒	☐	☐	6-22-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
RALPH W. BALLIN, M.D.	51 GREENE ST CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/24/71	Laurel Hill Cemetery	Nr. Barton Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George GEORGE FUNERAL HOME, 202 GREENE ST., CUMB. MD.	JUN 28 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

08259

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08261

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farwarded to the Chief Medical Examiner's Office along with Form [illegible] Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: Mary	Middle: Theresa	Last: Minke	2a. DATE OF DEATH KNOWN ☒ / ESTIMATED ☐: Month 6 Day 26 Year 71	2b. HOUR: 9 a M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: June 5, 1912	6. AGE (In years last birthday): 59 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month June 26 Day, 1971 Year 19	2d. HOUR: 10a M
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Christie Road	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Owner	12b. KIND OF BUSINESS OR INDUSTRY: Recreation Area		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Christie Road	
14. FATHER'S NAME First: Jerome	Middle	Last: Burkey	15. MOTHER'S MAIDEN NAME First: Mary T.	Middle	Last: Miller
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Donald L. & Thomas J. Minke	ADDRESS: Sons Christie Rod.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary Sclerosis — ---
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county): Cumberland, Md.
22b. DATE SIGNED: June 26, 1971

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: June 29, 1971	23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland, Alleg. Md.	
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. REGISTRAR DATE: JUN 30 1971	25b. REGISTRAR'S SIGNATURE: Vernon G. Randall	

VR A15ME (8)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08260 Item#5, Film G437 6/24/71 kam

CERTIFICATE OF DEATH

08262

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
NORMAN	E	MONNETT	6	8	71	I:0[illegible]

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	10-27-98 1897	73 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
WEST VIRGINIA	UNITED STATES	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL	RETIRED TRACKMAN	RAILROAD

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBEREAND	YES [ ] NO [ ]	RT. #4 BOX 240,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOSEPH	WILLIAM	MONNETT	ANNA		MC KENZIE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
UNKNOWN	NONE	705-09-7028	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days.

552 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Intestinal Obstruction, Small Intestine, Large — 5 days.

DUE TO, OR AS A CONSEQUENCE OF (c) Scrotal Hernia, Diabetes, ASCVD, pyloric stenosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2 days

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
3 days	Intestinal Obstruction	YES [ ] NO [X]	

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner)	UNDERLYING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Carlton Brinsfield	MD	[ ]	[ ]	[X]	6-8-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. C. BRINSFIELD	401 DECATUR ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 12, 1971	Lechliter Cemetery	Near Ridgeley, W.Va.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD. BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JUN 11 1971	Vernon A. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08261 Item#13, Film G437 6/18/71 kam

08263

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: GEORGE	Middle: ALBIN	Last: MOODY	2a. DATE OF DEATH: Month 6 Day 11 Year 71	2b. HOUR: 8:40 A M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 1-16-96	6. AGE (In years last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: CUMBERLAND TRANSIT CO.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 139 N. Mechanic John F. Kennedy Homes St. CUMBERLAND NURSING HOME	
14. FATHER'S NAME: First WILLIAM	Middle	Last MOODY	15. MOTHER'S MAIDEN NAME: First ANNA	Middle	Last MOWBRAY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES	(If yes give war or dates of service): W.W.I	16b. SOCIAL SECURITY NO.: 214-10-5156	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart disease — Years

DUE TO, OR AS A CONSEQUENCE OF (c): Hypertensive Cardiovascular Disease — Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from June 7, 19 71, to June 11, 19 71, that (I) (we) last saw the deceased alive on June 11 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 6/12/71

22d. PHYSICIAN'S NAME (Type): DR. B. SCHINDLER-PA — 22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: JUNE 14, 1971	23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State): CUMBERLAND ALLEGANY MD.	
24. FUNERAL DIRECTOR: SILCOX-MERRITT FUNERAL SERVICE	ADDRESS: CUMBERLAND MD.	25a. REC'D BY REGISTRAR DATE: JUN 14 1971	25b. REGISTRAR'S SIGNATURE: Vernon G. Randall	

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08262

CERTIFICATE OF DEATH

08264

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
ALVIRTIA	M	MORRIS	6	16	71	1:40 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
FEMALE	WHITE	11-29-07	63 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W.VA.	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	RAWLINGS	YES [ ] NO [X]	BOX 28A

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
CRAWFORD	B	MYERS	SARA		SIMPSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	214 05 6720	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) 1 week (b) years (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS / DR CONTRIBUTING (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
UNDERLYING [ ] CAUSE OF DEATH [ ]		

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
[ ] / [ ]					

22a. **I certify** that (I) (this hospital) attended the deceased from January 1, 19 71, to 6/16, 19 71, that (I) (we) last saw the deceased alive on 6/16 19 71 and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	MD PA	[X]	[ ]	[ ]	6/17/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. B. SCHINDLER-PA	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	19 June 71	Meadow Point	Keyser Mineral W.Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Allen M. Kotenski	85 S. Main Keyser, W.Va.	JUN 28 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08263

CERTIFICATE OF DEATH

08265

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
LEONA		MYERS	6 Month 5 Day 71 Year	3:35 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	6-12-06	64 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	UNITED STATES		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of wark done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	Allegany	LONACONING	YES ☒ NO ☐	19 DOUGLASS AVE.

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
ELIS W. MYERS	BERTHA SHAVER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
	213-22-3804	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7-8 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Pancreas — 1 year

DUE TO, OR AS A CONSEQUENCE OF (c)

1579

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
27 apr. 71	Laparotomy & biopsy tumor & liver	YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 ar Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street ar R.F.D. No.	City ar Town	County	Stote

22a. **I certify** that (I) (this hospital) attended the deceased from 19 apr., 1971, to 5 June, 1971, that (I) ~~(two)~~ last saw the deceased alive an 4 June 1971, and that in (my) ~~(our)~~ apinian death accurred an the date and haur and from the causes stated abave, (I) ~~(we)~~ ~~(did)~~ (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
W. Alfred Van Ormer	M.D.	☒	☐	☐	5 apr. 71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. W.A. VAN ORMER	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	6/8/71	Memorial Park	Frostburg	A.	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	JUN 9 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08264 — 08266

1. DECEASED-NAME (Type or print)	First: CLAUDE	Middle: FELIX	Last: NAVE Sr.	2a. DATE OF DEATH: 06 Month 18 Day 71 Year		2b. HOUR: M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 03-16-88		6. AGE (In years last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): PENNA.	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH: ALLEGANY, Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RUBBER WORKER	12b. KIND OF BUSINESS OR INDUSTRY: RUBBER				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 179 N. MECHANIC ST.			
14. FATHER'S NAME: First ELZA	Middle WILSON	Last NAVE	15. MOTHER'S MAIDEN NAME: First LANUI	Middle RENA	Last NAVE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: HOSPITAL CHART	Address: 900 SETON DR., CUMBERLAND, MD.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124
DUE TO, OR AS A CONSEQUENCE OF (b): A.S.C.V.D.
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Renal Insufficiency & Obstructive lung disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
UNDERLYING CAUSE OF DEATH [ ] DR CONTRIBUTING [ ]	HOUR A.M. P.M. Month Day Year 19	

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
While at work [ ] Not while at work [ ]					

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Clarence L. Vincent M.D.		[X]	[ ]	[ ]	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
C. VINCENT, M.D.	924 SETON DR., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	6/21/71	Hillcrest Burial Pk	Cumb.	Allegany	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
LOUIS STEIN, INC.	117 FREDERICK ST., CUMB. MD.	JUN 22 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

08265

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08267

1. DECEASED-NAME (Type or Print): First Loretta Middle Frances Last Noone

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Month June Day 20 Year 1971 — 2b. HOUR 11 PM

3. SEX: Female — 4. RACE: White — 5. DATE OF BIRTH: May 28, 1898 — 6. AGE (In years last birthday): 73 YRS. IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN.

2c. DATE PRONOUNCED DEAD: Month June Day 20 Year 1971 — 2d. HOUR 11 PM

7a. BIRTHPLACE (State or foreign country): W. Va. — 7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Allegany Md.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 16 N. Waverly Terrace

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. — 13b. COUNTY: Allegany — 13c. CITY OR TOWN: Cumberland — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: 16 N. Waverly Terrace

14. FATHER'S NAME: First Norbert Middle T. Last O'Donnell

15. MOTHER'S MAIDEN NAME: First Rosa Middle (Rose) Last Swankhouse

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.

17. INFORMANT: Daughter — ADDRESS: Mrs. Kathleen Ibanez, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Sclerosis — --

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. — City or Town — County — State

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelis M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: June 21, 1971 — Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE: June 23, 1971 — 23c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery — 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: JUN 24 1971 — 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08266 08268

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
CHARLES	GILBERT	RASE	06 10 71	A 12:50 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	09 01 06	64 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	KELLY SPRINGFIELD TIRE	COMPANY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	BECKHART	YES ☐ NO ☐	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN		RASE	(NELSON) FANNIE		RASE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		214 07 0721	SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,	MD. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Stomach 1 year

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Nov 70	Ca of Stomach	YES ☐ NO ☒	

21a. ACCIDENT WAS OR CONTRIBUTING ☐ (If either, notify medical examiner)	UNDERLYING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Nov, 19 70, to 10 June, 19 71, that (I) (we) last saw the deceased alive on 9 June 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Fred W. Miltenberger M.D.		☒	☐	☐	10 June 71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
F.W. MILTENBERGER, M.D.	122 S. CENTRE ST., CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	6-12-71	Rest Lawn Mem. Park	LaVale	Allegany	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Hafer-Sower Funeral Home	FROSTBURG, MD. 21532	JUN 16 1971	Vernon R. Randall

DHMH-16 1/71 30M
(VR A15 (4))

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08267

CERTIFICATE OF DEATH

08269

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
GEORGE	N	REUSCHEL	6 Month 8 Day 71 Year	2:25 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	2-20-15	XX XX 56 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	UNITED STATES	MARRIED X	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Carpenter	Building

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES / NO X	ROUTE 1, BOX 139

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
PHILLIP		REUSCHEL	DAISY		MALCOLM

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes 19-20 (Inclusive dates of service)	217-10-1983	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myocardial Infarction	6 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary occlusion	6 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerotic Heart Disease	unknown

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES / NO	

21a. ACCIDENT WAS OR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** thot (I) (this hospitol) attended the deceased from 6/2, 19 71, to 6/8, 19 71, that (I) (we) last saw the deceased alive an 6/7 19 71, and that in (my) (our) opinian death occurred an the date ond hour and from the causes stated above. (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	MD	X			6/9/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. S.G. WEISMAN	CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11 June 71	Hillcrest Burial Park	Cumberland, Allegany Co., Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECEIVED BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harvey H. Zeigler, Hyndman, pa. 15545	JUN 15 1971	Vernon G. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08268 08270

1. DECEASED-NAME (Type or print): First ANNA Middle HILDA Last RUEHL
2a. DATE OF DEATH: Month 06 Day 24 Year 71
2b. HOUR: 4:00 PM
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: 8-10-99
6. AGE (In years last birthday): 71 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES
8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Dental Assistant
12b. KIND OF BUSINESS OR INDUSTRY: Dentistry
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 4 MARKET ST.
14. FATHER'S NAME First WILLIAM Middle Last RUEHL
15. MOTHER'S MAIDEN NAME First (SCHNEIDER) Middle SOPHIA Last RUEHL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 214-05-4670
17. INFORMANT Address: HOSPITAL RECORD, 900 SETON DR., CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: WEEKS
DUE TO, OR AS A CONSEQUENCE OF
(b): ARTERIOSCLEROTIC HEART DISEASE — YEARS
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
PULMONARY EMPHYSEMA, SEVERE

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, natify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 5/31, 19 71, to 6/24, 19 71, that (I) (~~we~~) last saw the deceased alive on ~~5/31~~ 6/24 19 71, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: R C Espina
DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 6/24/71
22d. PHYSICIAN'S NAME (Type): RENATO ESPINA, M.D.
22e. ADDRESS: 924 SETON DR., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6/26/71
23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.
24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: GEORGE FUNERAL HOME, 202 GREENE ST. CUMBERLAND MD.
25a. REC'D BY REGISTRAR DATE: JUN 28 1971
25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

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DHMH-16 1/71 30M
(VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08269 Item#8, Film G438 7/6/71 kam

CERTIFICATE OF DEATH

08271

1. DECEASED-NAME (Type or print) First	Middle	Last	2o. DATE OF DEATH Month	Day	Year	2b. HOUR
ROY	P	SATZER	6	20	71	7:55 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	3 I 25	46 YRS.		

7o. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
PENNA.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	BALLISTICS	ALLEGANY

13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES ☒ NO ☐	340 ALLEGANY ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN	A	SATZER	BLANCHE		MASON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	WW 2	218 16 4657	MEMORIAL HOSPITAL,	CUMBERLAND, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO, OR AS A CONSEQUENCE OF

(b) Pressure infarctions — 4 yrs

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
			Cumberland	Allegany	Md

22o. **I certify** that (I) (this hospital) attended the deceased from 3/16/69, 19___, to 4/20/71, 19___, that (I) ~~(we)~~ last saw the deceased alive on 4/20/71, 19___, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	MD	☒	☐	☐	6/22/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. R.J. WILLIAMS	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	6-23-1971	FROSTBURG MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST SR. FROSTBURG, MD. 21532	JUN 28 1971	Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08270 08272

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
GEORGE	D	SAUM	6 8 71	10:10A

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	7-7-04	66 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
WEST VIRGINIA	UNITED STATES	NEVER MARRIED X	ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND,	MEMORIAL	RETIRED	ROOFING

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES X NO	504 WASHINGTON STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
RUSSELL		SAUM	MARGARET		STUIBER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
UNKNOWN		220-07-6090	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Chronic pulmonary insufficiency	6 months
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic and Hypertensive Cardio-	15 years
DUE TO, OR AS A CONSEQUENCE OF (c)	vascular disease with myocardial infarction	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4122

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Arteriosclerosis of the aorta & resection abdominal aneurysm

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS / DR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 71, to 6/8, 19 71, that (I) (we) last saw the deceased alive on 6/8 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	MD	X			6/9/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. S. WEISMAN	59 GREENE STREET CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	6/11/71	HILLCREST BURIAL PARK	CUMBERLAND, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	JUN 14 1971	Vernon R. Randall

VR A15 (1)
25m-1/70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

08271

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08273

1. DECEASED-NAME (Type or Print) First	Middle	Last
WILLIAM	IRVIN	SCOTT

2a. DATE OF DEATH ESTIMATED ☒ Month June Day 4, Year 71 — 2b. HOUR 8p M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	3-26-1949	22 YRS.		

2c. DATE PRONOUNCED DEAD Month June Day 5, Year 1971 — 2d. HOUR 1:50 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED ☒ / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MD.	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital-DOA	STUDENT	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	FROSTBURG	YES ☒ NO ☐	206 ALBERT AVE.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JACOB		SCOTT	SUSAN		HANEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	212-54-8306	JACOB SCOTT	206 ALBERT AVE FROSTBURG

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Asphyxiation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

9109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) (Drowning) — "

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
	8:00 P.M. 6-4-71 19	Aacidental Drowning in Strip Mine Pit

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State
	Naked Lake	Midland, Allegany, Maryland

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED June 5, 1971

ADDRESS (Street, city, town, or CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	6-8-1971	FROSTBURG MEMORIAL	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST SR. FROSTBURG, MD.	JUN 14 1971	Vernon G. Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08272 08274

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: Nelson	Middle:	Last: Shatto	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Doy Year: 6-22-71 19	2b. HOUR: 2p M	
3. SEX: Male	4. RACE: Korean	5. DATE OF BIRTH: May 30,1955	6. AGE (In years last birthday): 16 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Doy Year 19: 6-22-71	2d. HOUR: 2:33 p M
7a. BIRTHPLACE (State or foreign country): Korea	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital-DOA	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Student	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 744 Fayette St.	
14. FATHER'S NAME First: Joseph W.	Middle:	Last: Shatto	15. MOTHER'S MAIDEN NAME First: Ruth	Middle: Beard	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: Mother: Ruth Shatto			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Asphyxiation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: =Minutes

DUE TO, OR AS A CONSEQUENCE OF (b): (Drowning)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

9100

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [ ]	
21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.: 2 pm 6-22-71	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Drowned while swimming	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Quarry Pond	21f. LOCATION Street or R.F.D. No. City or Town County State: South of Ellerslie, Allegany, Maryland	

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X] Inquiry [X] and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]

22b. DATE SIGNED: June 22, 1971

ADDRESS (Street, city, town or county): Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Anatomical Board	23b. DATE: 6-22-71	23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board	23d. LOCATION (City or Town) (County) (State): Baltimore, Maryland	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE: JUN 25 1971	25b. REGISTRAR'S SIGNATURE: Vernon O. Randall	

VR A15ME (5) 10M - 1/69

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08273 08275

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be returned to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ANNA	ELIZABETH	SHERMAN	06 05 71	3:45 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
FEMALE	WHITE	08-26-90	80 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W. VA.	UNITED STATES	WIDOWED [X]	ALLEGANY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	NONE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W. VA.	MINERAL	KEYSER,	YES [X] NO [ ]	25 S. F STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JACOB		WHISNER	XXXXXXXX	ISADORA	MORNINGSTAR

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	None	234-48-3376	HOSPITAL CHART, 900 SETON DR., CUMBERLAND, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Aspiration severe esophageal dysphinisia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mo

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)

4/24

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Congestive heart failure related to ASCVD.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH / OR CONTRIBUTING (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 5 June, 19 71, that (I) (we) last saw the deceased alive on 5 June 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Earl W. Campbell M.D.	ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	5 June 71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
E.W. CAMPBELL, M.D.	912 SETON DR., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/8/71	Philos Cemetery	Westernport, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
MARKWOOD FUNERAL HOME, KEYSER, W. VA. Harold W. McKenzie	JUN 10 1971	Vernon R. Randall

DHMH-16 1/71 30M (VR A15 (4))

E.W. CAMPBELL, M.D.

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

08274

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08276

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: Olive	Middle: F.	Last: Shirey	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ Month: 6 Day: 29 Year: 71 19		2b. HOUR: 4 pM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: June 6, 1887	6. AGE (In years last birthday): 84 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month: June Day: 29 Year: 1971 19	2d. HOUR: 10p M
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 620 Washington St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 620 Washington St.	
14. FATHER'S NAME First: Walter	Middle	Last: Powell	15. MOTHER'S MAIDEN NAME First: Mary	Middle	Last: Dart
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Orville C. Shirey	ADDRESS: Silver Spgs., Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4109

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Sclerosis — ---

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.DD.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: June 29, 1971

ADDRESS (Street, city, town, or county): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 7-2-71	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill	23d. LOCATION (City or Town) (County) (State): Cumberland, Alleg. Md.	
24. FUNERAL DIRECTOR ADDRESS: Louis Stein, Inc. Cumberland, Maryland	25a. RECEIVED BY REGISTRAR DATE: JUL 6 1971	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall		

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08275

CERTIFICATE OF DEATH

08277

1. DECEASED-NAME (Type or print) First: Mary Middle: ELIZABETH Last: ~~Slyrock~~ SHRYOCK
2a. DATE OF DEATH Month: 6 Day: 25 Year: 71
2b. HOUR: 7 45 M
3. SEX: F
4. RACE: White
5. DATE OF BIRTH: 12-30-1903
6. AGE (In years last birthday): 67 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Piedmont W.Va
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Cumberland Nursing Center
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: Rt. 6 Oldtown Road.
14. FATHER'S NAME First: Albert Middle: Last: Heavner
15. MOTHER'S MAIDEN NAME First: Bessie Middle: Last: Hyre
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16b. SOCIAL SECURITY NO.: ~~222-36-5004~~ ~~#1-5-6574~~
17. INFORMANT: Mr. Terry Slyrock Address: 508 Ridge wood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO, OR AS A CONSEQUENCE OF (b): Breast cancer — 3 years
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1744

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 1968, to June 25, 1971, that (I) (we) last saw the deceased alive on June 24 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Thomas F Lewis MD DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 6/26/71
22d. PHYSICIAN'S NAME (Type): THOMAS F. LEWIS
22e. ADDRESS: 500 Greene St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6/28/1971
23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Park
23d. LOCATION (City or Town) (County) (State): Near Cumberland Alleg Md.
24. FUNERAL DIRECTOR: John J. Hafer
ADDRESS: Hafer Funeral Service, 230 Balto Ave Cumberland Md
25a. RECD. BY REGISTRAR DATE: JUN 30 1971
25b. REGISTRAR'S SIGNATURE: Vernon G. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M · 1/69

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

08276

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08278

1. DECEASED-NAME (Type or Print) First: James	Middle: Thomas	Last: Shugars	2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ Month Doy Yeor: 6-11-71 19	2b. HOUR: 8 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 9- -44	6. AGE (In years last birthday): 26 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month June Day 11, Year 1971 19	2d. HOUR: 8:45PM
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Sacred Heart Hospital--DOA	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Miner	12b. KIND OF BUSINESS OR INDUSTRY: Coal Mine		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W.Va.	13b. COUNTY: Mineral	13c. CITY OR TOWN: Keyser	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 173 S.Davis Street	
14. FATHER'S NAME First: George	Middle: H	Last: Shugars	15. MOTHER'S MAIDEN NAME First: Carrie	Middle: V	Last: Bowman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 228-60-3773	17. INFORMANT ADDRESS: George H. Shugars, Westernport, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Asphyxiation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8161

DUE TO, OR AS A CONSEQUENCE OF (b): Compression of Chest and Abdomen by — "

DUE TO, OR AS A CONSEQUENCE OF (c): overturned automobile

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. 8:00 P.M. 6-11-71 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.): Passenger (front) in one car accident
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): W.Va.Rt.8 Near ABL	21f. LOCATION Street or R.F.D. No. / City or Town: Pinto / County: Allegany / State: Maryland

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: June 11, 1971

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/14/71	23c. NAME OF CEMETERY OR CREMATORY: Cabin Run Cemetery	23d. LOCATION (City or Town) (County) (State): Keyser Mineral W.Va.	
24. FUNERAL DIRECTOR: E. L. Burl	ADDRESS: Westernport, Md.	25a. REC'D BY REGISTRAR DATE: JUN 17 1971	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

VR A15ME (5)
IDM - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

08277

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08279

1. DECEASED-NAME (Type or Print) First: Adolpheus	Middle:	Last: Smith	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month Day Year: June 18, '71	2b. HOUR: 6p M		
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH: 12/21/1932	6. AGE (In years last birthday): 38 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month Day: June 18, 1971 Year 19	2d. HOUR: 6:30 pm	
7a. BIRTHPLACE (State or foreign country): Mississippi	7b. CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany		Md.	
10. CITY OR TOWN OF DEATH: 1 Mile East of Flintstone Rt. # 40	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: New York	13b. COUNTY: Kings	13c. CITY OR TOWN: Brooklyn	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 293 Dumgreen Place ~~450 Jewday Street~~		
14. FATHER'S NAME First: Adolpheus	Middle:	Last: Smith	15. MOTHER'S MAIDEN NAME First: Williemae	Middle:	Last: Jefferson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes give war or dates of service): WW 2	16b. SOCIAL SECURITY NO.: 425-56-4773	17. INFORMANT ADDRESS: 222 North Front St.,	Stitt Funeral Home Reading, Penna		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Burns of Entire Body — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF (b): (Conflagration of Motor Truck resulting from Accident) — --

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8120

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year: HOUR A.M. 6 P.M. 6-18-71 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Driver of Truck involved in Collision.
21d. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Rt.#40	21f. LOCATION Street or R.F.D. No. / City or Town / County / State: One Mile East of Flintstone, Allegany, Maryland

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: June 18, 1971

ADDRESS (Street, city, town, and State): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/25/71	23c. NAME OF CEMETERY OR CREMATORY: Forest Hill Memorial Park	23d. LOCATION (City or Town): Reading	(County): Beirks	(State): Penna
24. FUNERAL DIRECTOR: John J. Hafer, Jr.	ADDRESS: Cumberland Md	25a. REC'D BY REGISTRAR DATE: JUN 25 1971	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall		
Hafer Funeral Service, 230 Balto Ave.					

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 on page 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08278

CERTIFICATE OF DEATH

08280

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
PATRICIA	LYNN	SMITH	6 30 71	3:15 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	6-28-71		2	

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	UNITED STATES		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	NONE	NONE

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	616 ELM STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
RICHARD	E	SMITH	JOYCE	EILEEN	PARK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	800-01-0802	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7759 IMMEDIATE CAUSE (a)	RESPIRATORY ARREST	2 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Possible CNS Bleed	2 days
DUE TO, OR AS A CONSEQUENCE OF (c)	ERYTHROBLASTOSIS FETALIS	2 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).
EXCHANGE TRANSFUSION done AT 1½ hours of life

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			NO

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from 6-28 19 71, to 6-30 19 71, that (I) (we) last saw the deceased alive on 6-30 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	M.D.	☒	☐	☐	6-30-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. ROBERT BRODELL, CMG	CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	July 1, 1971	Hillcrest Burial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JUL 6 1971	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08279 — 08281

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
STELLA	G.	SMITH	06 03 71	3:02 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	7-17-79	91 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
OHIO	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	HOUSEWIFE	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	640 HILLTOP DR.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOSEPH	C.	GORDON	CLARA	COREY	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
		MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart Failure	Months
DUE TO, OR AS A CONSEQUENCE OF (b)	Anemia	Months
DUE TO, OR AS A CONSEQUENCE OF (c)	Generalized arteriosclerosis	Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from MAY 26, 19 71, to June 3, 19 71, that (I) (we) last saw the deceased alive on June 3, 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐		6/4/71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. B. SCHINDLER-PA	43 GREENE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 5, 1971	Rose Hill Mausoleum	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	JUN 9 1971	Vernon O. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(M)
25m-1/70

Item 18c Film 438 7/6/71

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08280 — 08282

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Lillian	Middle V.	Last Souders
2a. DATE OF DEATH Month Doy Yeor	6/21/71		2b. HOUR 5:40 PM
3. SEX	F		
4. RACE	W		
5. DATE OF BIRTH	8/11/94		
6. AGE (In yeors last birthday)	76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country)	West Virginia	7b. CITIZEN OF WHAT COUNTRY?	U.S.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒		9. COUNTY OF DEATH	Allegany Md.
10. CITY OR TOWN OF DEATH	Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	Cumberland Nursing and Convales. Center
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Waitress	12b. KIND OF BUSINESS OR INDUSTRY	Restaurant
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.	13b. COUNTY	Allegany
13c. CITY OR TOWN	Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET AND NUMBER	924 Glenwood St.		
14. FATHER'S NAME First Middle Last	Arthur T. Souders	15. MOTHER'S MAIDEN NAME First Middle Last	Ora Paul
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	no	16b. SOCIAL SECURITY NO.	578-22-5394A
17. INFORMANT Address	Mr. Charles R. Souders, Short Gap, W.Va.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
342X	IMMEDIATE CAUSE (a) Grade 4 arteriosclerotic Heart disease congestive	4 years
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.	DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease	4 years
	DUE TO, OR AS A CONSEQUENCE OF (c) Parkinsonian's Disease	4 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. **I certify** thot (I) (this hospitol) attended the deceased from 5-12, 19 71, to 6-21, 19 71, thot (I) (we) lost sow the deceased olive on June 8, 19 71, ond that in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted obove, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED 6/22/71
22d. PHYSICIAN'S NAME (Type) Dr. Blane M. Schindler, M.D. P.A.	22e. ADDRESS 43 Greene Street Cumberland, Maryland 21502		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)	
Burial	June 24, 1971	Hillcrest Burial Park	Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, Md.		JUN 28 1971	Vernon R. Randall	

VR A15 (4)
45M - 1/69

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08281 08283

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: ALEXANDER	Middle: HILL	Last: STAFFORD	2a. DATE OF DEATH: Month 6 Day 2 Year 71	2b. HOUR: 4:20 PM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 09-16-07	6. AGE (In years last birthday): 63 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): MACHINE REPAIR	12b. KIND OF BUSINESS OR INDUSTRY: CELANESE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: LONACONING	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 1 SELDOM SEEN RD.		
14. FATHER'S NAME First: THOMAS	Middle	Last: STAFFORD	15. MOTHER'S MAIDEN NAME First: SEXTON	Middle: NETTIE	Last: STAFFORD	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 213-10-5282	17. INFORMANT: PT'S. HOSP. RECORD	Address: 900 SETON DR. CUMB., MD.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 hours?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Heart Disease — 2 years
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 70, to 6/2, 19 71, that (I) (we) last saw the deceased alive on 6/2 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] M.D. DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 6/4/71
22d. PHYSICIAN'S NAME (Type): DR. S.G. WEISMAN
22e. ADDRESS: 59 GREENE STREET CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/5/1971	23c. NAME OF CEMETERY OR CREMATORY: Memorial Park	23d. LOCATION (City or Town) (County) (State): Frostburg, Md.	
24. FUNERAL DIRECTOR: EICHHORN FUNERAL HOME	ADDRESS: 8 E. MAIN ST. LONACONING	25a. REC'D BY REGISTRAR DATE: JUN 9 1971	25b. REGISTRAR'S SIGNATURE: Vernon O. Randall	

DHMH-16 1/71 30M
(VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08282

08284

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Copies 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print) First	ELIZABETH	Middle LILLIAN	Last THOMAS
2a. DATE OF DEATH Month 06 Day 19 Year 71	2b. HOUR 8:00 PM		
3. SEX	FEMALE		
4. RACE	WHITE		
5. DATE OF BIRTH	FEBRUARY 28, 1919		
6. AGE (In years last birthday)	52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country)	PENNSYLVANIA		
7b. CITIZEN OF WHAT COUNTRY?	UNITED STATES		
8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]			
9. COUNTY OF DEATH	ALLEGANY COUNTY Md.		
10. CITY OR TOWN OF DEATH	CUMBERLAND, MD.		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	SACRED HEART		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	HOUSEWIFE		
12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	WEST VIRGINIA		
13b. COUNTY			
13c. CITY OR TOWN	NEW CREEK		
13d. INSIDE CITY LIMITS?	YES [ ] NO [X]		
13e. STREET AND NUMBER	Box 156		
14. FATHER'S NAME First	WILLIAM	Middle LEONARD	Last POCKNELL
15. MOTHER'S MAIDEN NAME First	LILLIAN	Middle ELIZABETH	Last DAVIS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	NO	(If yes give war or dates of service) None	
16b. SOCIAL SECURITY NO.	254-16-2069		
17. INFORMANT	HOSPITAL RECORD,	Address SACRED HEART HOSPITAL 900 SETON DR., CUMB., MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

174 X

IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mon

DUE TO, OR AS A CONSEQUENCE OF (b) Breast Adenocarcinoma — 6 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) UNDERLYING [ ] CAUSE OF DEATH [ ]	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I **certify** that (I) (this hospital) attended the deceased from Oct, 19[illegible], to 6-19, 1971, that (I) (we) last saw the deceased alive on 6-19 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)	WAYNE SPIGGLE, M.D.	22e. ADDRESS	912 SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	June 22, 1971	23c. NAME OF CEMETERY OR CREMATORY	Potomac Valley Mem. Park, Keyser, Mineral, W.Va
24. FUNERAL DIRECTOR	ADDRESS	MARKWOOD FUNERAL HOME, KEYSER, WEST VIRGINIA	25a. REC'D BY REGISTRAR DATE	JUN 24 1971	25b. REGISTRAR'S SIGNATURE Vernon G. Randall

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08283 — 08285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: William	Middle:	Last: Thompson	2a. DATE OF DEATH Month: 6	Day: 10	Year: 71
2b. HOUR: M	3. SEX: M	4. RACE: W	5. DATE OF BIRTH: 1-22-09	6. AGE (In years last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.			
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Board of Education	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 434 Industrial Blvd.		
14. FATHER'S NAME First: Goven	Middle: Thompson	Last:	15. MOTHER'S MAIDEN NAME First: Margaret Jane	Middle:	Last: Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes	(If yes give war or dates of service): War # 2	16b. SOCIAL SECURITY NO.: 314-07-5930	17. INFORMANT: Irene Thompson (WIFE)	Address: Cumberland, Md		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 0

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Disease — 20 yr

DUE TO, OR AS A CONSEQUENCE OF

(c): Arteriosclerosis

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Atrial fibrillation — Congestive Heart failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Victor Mozzocco	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 6-10-71
22d. PHYSICIAN'S NAME (Type): Victor Mozzocco		22e. ADDRESS: Cumberland, Md.			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/12/1971	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State): Cumberland, Md.	
24. FUNERAL DIRECTOR: GEORGE EICHHORN	ADDRESS: Lonaconing, Md.	25a. REC'D BY REGISTRAR DATE: JUN 14 1971	25b. REGISTRAR'S SIGNATURE: Vernon A. Randall	

VR A(5-71)D
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08284

CERTIFICATE OF DEATH

08286

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
TINA	a	UNDERDONK	6	20	71	4:45 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	10 28 96	74 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PENNA	UNITED STATES	WIDOWED [X]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of warking life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	617 LOUISIANA AVE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Amos	James	[redacted]	Mary	J	Fisher

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	—	—		MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion with Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS / OR CONTRIBUTING (If either, natify medical examiner)	UNDERLYING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part I ar Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Nat while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. Na.	City ar Town	County	State

22a. I certify thot (I) (this hospitol) attended the deceased from 6-19-71, 19__, to 6-20-71, thot (I) (saw) lost saw the deceased olive on 6-19-71 19__, ond that in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above, (I) (saw) (did) (did not) view the body after deoth.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. / MED. DIRECTOR / STAFF PHYS.	22c. DATE SIGNED
	ATTENDING PHYS. [X]	6-20-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. G.O. HIMMELWRIGHT	CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/23/71	Hillcrest Burial Pk.	Cumb. Allegany Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Davis Stein Inc.	Cumb. Md	JUN 25 1971	Vernon G. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

1 5 08285

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08287

1. DECEASED-NAME (Type or print) First: JOHN Middle: J Last: WALLACE	2a. DATE OF DEATH Month: 6 Day: 17 Year: 71	2b. HOUR: 3:22P	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 3 27 97	6. AGE (In years last birthday): 74 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ] 13e. STREET AND NUMBER: 404½ N. CENTRE ST.
14. FATHER'S NAME First: THEODORE Middle: Last: WALLACE	15. MOTHER'S MAIDEN NAME First: MARY Middle: B. Last: GOETZ		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214 07 4900	17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.	

50 01 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4379

IMMEDIATE CAUSE (a) Hypostatic pneumonia. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular insufficiency. — 1 year.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

2

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [✓]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 3/20, 1971, to 6/17, 1971, that (I) (we) last saw the deceased alive on 3/17 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: P. B. Halmos	MD DEGREE	ATTENDING PHYS. [✓] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 6/18/71
22d. PHYSICIAN'S NAME (Type): DR. PETER B. HALMOS	22e. ADDRESS: CUMBERLAND, MD.		

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/19/71	23c. NAME OF CEMETERY OR CREMATORY: Rose Mausoleum	23d. LOCATION (City or Town) (County) (State): Cumb. Allegany Md.
24. FUNERAL DIRECTOR: Louis Stein Inc.	ADDRESS: Cumb. Md.	25a. REC'D BY REGISTRAR DATE: JUN 22 1971	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

08286 08288

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
GEORGE	E	WARD	06 13 71	8:17 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	10-15-18	52 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	CELANESE FIBERS	FIBER INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [ ] NO [X]	BOX 301, BEDFORD RD.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
GEORGE	E.	WARD	(POORBAUGH) GLADYS		WARD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
YES WW-2	214-07-3456	HOSPITAL RECORD, 900 SETON DR., CUMBERLAND, MD. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LEUKEMIA, ACUTE, MYELOIC — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS
2050
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
RHEUMATIC HEART DISEASE EPILEPSY, GRAND MAL

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING UNDERLYING [ ] CAUSE OF DEATH [ ] (If either, natity medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10 - 7, 1958, to 6 - 13, 1971, that (I) (we) last saw the deceased alive on 6 - 12 1971, and thot in (my) (our) opinian death occurred on the date and haur and from the causes stoted above, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
R. Ballin	M.D.	[X]	[ ]	[ ]	6-13-71

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
R.W. BALLIN, M.D.	51 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/16/71	Zion Memorial Park	Cumberland Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
KIGHT FUNERAL HOME, 309 DECATUR ST., CUMB., MD. 21502	JUN 18 1971	Vernon O. Randall

DHMH-16 1/71 30M
(VR A15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Burial 8/16/71 Zion Memorial Park Cumberland Allegany Md.

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

08287

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08289

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 943. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last
Thomas	Argyle	Wilson

2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month	Day	Year	2b. HOUR
6-	21-	71 19	5p M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.
Male	White	2/28/1896	75 YRS				

2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
June	21,	1971 19	5p M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	U S A		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	DOA-Memorial Hospital	Retired, Boss Foreman	Kelly Springfield

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany Nr.	Flintstone	YES [ ] NO [XX]	Mailing Address Route 1, Oldtown, Md

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Argyle		Wilson	Matilda		Twigg

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 1	214-07-0305	Mrs. Minnie Wilson, ~~Tom~~	Route 1, Oldtown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

907X

IMMEDIATE CAUSE (a) Electrocution — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) (Struck by Lightning)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [XX]

21a. EXTERNAL CAUSE WAS PRIMARY [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
about	4:30 P.M. 6-21-71	Was out in Field when struck

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Own Farm	Flintstone,		Allegany,	Maryland

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [XX] and in my opinion death resulted from: Natural causes [ ], Accident [XX] Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Benedict Skitarelic M.D. / Benedict Skitarelic, MD.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]
ADDRESS (Street, city, town, or county): Cumberland, Maryland

22b. DATE SIGNED: June 21, 1971

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	6/24/1971	Sunset Memorial Park	Nr. Cumberland	Alleg	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Hafer Funeral Service	230 Balto Ave Cumberland Md	JUN 24 1971	Vernon R. Randall

VR A15ME (5) 10M - 1/69